Oklahoma HCBS Settings Rule Summary

All states are to provide the following information to CMS to document state and provider compliance with the regulatory criteria:

Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations;

I. Review Methodology

This section details how the State approached the systemic review for the Statewide Transition Plan. The State utilized a three-pronged approach for the review. The review began with the State lead compiling and reviewing all related regulations, contracts, policies and procedures, and service definitions. It was the responsibility of the State lead, the State Medicaid agency, to compile this information, assess it, and define its consistency to the HCBS Final Rule. The second prong of the process was a review by the State leads' partner agencies. These partner agencies included the Oklahoma Department of Human and Services (DHS) Developmental Disabilities Services Division and the Aging Services Divisions (ASD). These partner agencies had the responsibility of reviewing the assessed regulation, policies and procedures, and service definitions. Partner Agencies were responsible for adding additional regulations and policies that were not previously identified. Partner Agencies assessed each of the regulations and policies consistency/compliance with the HCBS final rule. Partner Agencies also proposed remediation and action plans for all regulations and policies that required such. The third prong of the systemic review process involved stakeholder groups. Stakeholders represented both the ICF/ID level of care waivers as well as the NFLOC waivers. The systemic assessment was sent to all stakeholder groups affiliated with the waivers. The stakeholder groups were charged with reviewing the systemic grid and providing feedback on the State leads and partner agencies determination of applicable regulations and policies and their consistency with the HCBS final rule. All feedback, comments, and suggestions were reviewed and incorporated as appropriate in the STWP and systemic assessment grids.

II. Compliance Analysis

Within the three-prong review process each group (State Lead, Partner Agencies, and Stakeholders) made an analysis of whether the identified relevant policies and regulations were consistent with the elements outlined the HCBS Final Rule. The analysis of the policies and regulations resulted in a determination of fully compliant, partially compliant, silent, or non- compliant with the elements of the HCBS Final Rule. The outcome was determined through an evaluation of the regulations and/or policies consistency and congruence with

elements of the HCBS final rule. Regulation and policy language precisely consistent and congruent with the elements were determined to be fully compliant. Policies and/or regulations consistent with only part of the elements of the HCBS Final Rule were determined to be partially compliant. Inconsistent language or language opposing the elements of the HCBS final rule was determined to be non-compliant. Absent language was determined to be silent. DHS DDS adopted an overarching general provision administrative rule to ensure clarity, consistency, and compliance across all waiver program settings. The overarching general provision administrative rule precisely follows the elements detailed in the HCBS Final Rule. As a result, it was determined that all ICF/ID LOC settings are compliant with the HCBS Final Rule. The systemic grid also includes supporting regulation and policies that enhance the consistency of the regulations and policies that address the elements in the HCBS Final Rule. Aging Services plans to adopt a similar overarching general provision administrative rule that will assist in its settings becoming more compliant with the HCBS Final Rule. Much of the regulations and policy pertaining to the NFLOC settings specifically Adult Day Health setting, remained silent; therefore, the adoption of an overarching administrative rule would more directly signify that settings must comply with the standards of the HCBS Final Rule.

III. Remediation Activities

NF LOC Waivers

Many of the current policy and regulations pertaining to settings in the NF LOC waivers were determined to remain silent or be partially compliant with the elements of the HCBS Final Rule. It has been determined that remediation is necessary to allow the settings to become compliant with the HCBS Final Rule. Remediation activities will consist of the development and addition of an overarching policy that will precisely follow language of the HCBS Final Rule that settings will have to abide by. The development of this standard for NF LOC waiver settings will go through the States permanent rule promulgation process. It is projected the proposed additional standards for NF LOC waiver settings will be effective 9/1/2017. A draft copy of the updated policy and language can be found in Appendix C.

ICF/ID LOC

The DHS DDS developed an overarching general provision standard that was made effective 9/1/2015. This standard pertains to and must be followed by all settings in the ICF/ID waivers. This overarching general provision strictly follows the language in the HCBS Final Rule. There are minimal instances where remediation is needed, specifically where the state policy and the waiver language conflict such as the case with the policy surrounding restraints. DHS has supporting policy that will be updated as a means of enhancing compliance and having additional policy to directly correspond with the HCBS Final Rule. Proposed changes to specific language can be found in Appendix D.

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Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance;

NF LOC - The DHS – Aging Services, Medicaid Services Unit, (MSU), Quality Assurance/Improvement (QAI) department Provider Audit team has begun formally conducting annual on-site provider agency reviews in all NFLOC settings. Settings including Assisted Living (AL), and Adult Day Health (ADH) onsite reviews were conducted in SFY17 (July 1, 2016 – June 30, 2017) and will continue annually after the transition plan period. The Provider Audit team has been conducting annual on-site reviews for Home Care (HC) and Case Management (CM) providers since 2000, and will continue these reviews, in accordance to the ADvantage Waiver performance measure requirements. Reviews are completed by DHS-AS MSU-QAI for /HCBS settings annually, extending beyond the transition period via the Consumer-Focused Quality Care Review (C-FQCR) tool. The C-FQCR is a tool that has multiple categories with a section dedicated for Home and Community Based settings compliance and Member survey responses. The C-FQCR is completed at the setting level with information from observations, Member level charts, and Member survey with all data linked to individual Members and the provider/setting. In accordance with the ADvantage Waiver, Raosoft is used to obtain a representative sample of case records of Members receiving services in each provider type reviewed, including ADH Members and Members who reside in an AL facility.

A proportionate sampling guide is created to determine how many Members are to be reviewed per setting. Once this sampling guide determines a minimum sample number per setting, a query is run to determine a random selection of Members for each setting. Included in each setting review is a survey of Member perception. Member Perception contacts are made with Members who were randomly selected for provider review in their ADH/AL setting, in the Member's home, or via telephone. These Member surveys are linked to the C-FQCR tool that combines data regarding compliance with contractual documents, Home and Community Based setting rules, state policy, and Member survey responses. Each setting review results are provided to the setting at an individual Member level, as well as a categorical level to determine areas of improvement. ADvantage does not currently have a Provider utilizing more than one setting type. If a provider had multiple types of settings, each setting would be reviewed separately. Providers with multiple locations have separate reviews for each location.

In SFY 2015, the State conducted baseline provider self-assessment surveys. By the end of SFY16, DHS-AS completed follow-up onsite reviews of Assisted Living facilities. In SFY16, DHS-AS also worked with DHS, Developmental Disabilities Services (DDS), to complete Adult Day site visit reports at the Adult Day Centers. During these follow-up reviews, DHS-AS found 71% of the seven AL providers reviewed were in full compliance while the other two AL settings and all 29 ADH settings were not in compliance but could be with modifications.

During SFY 2017, the *ADvantage* waiver commenced three new contracts with AL facilities that were not previously contracted. The three newly contracted AL facilities were

reviewed on-site using a Facility Evaluation tool with sections focusing on HCB Setting requirements and Heightened Scrutiny. These three settings are not included in the C-FQCR results because ADvantage Members are not placed in a facility until all requirements of the Facility Evaluation are met. The Facility Evaluation includes observation, interviews, review of policy and procedure, information collection, etc. to evaluate the facility's ability to appropriately serve HCBS recipients. This visit also includes a training element and is an opportunity to answer questions.

Examples of reasons a setting did not comply include the lack of community outing opportunities; unclear opportunities to provide change in Member needs and preferences; secure places for personal belongings; removal of gates, locked doors or other barriers to allow access to areas to the same degree of those not receiving HCBS; and providing members with information regarding how to update or change services and/or providers. Providers received feedback directly after each review regarding agency specific findings. In addition, a statewide overview of common findings and pertinent training reminders was provided at the Fall 2016 Regional Provider Trainings. Presentations were also given to ADH providers in January 2017 as a joint effort of DHS-AS and DHS-DDS to assure 100% compliance.

DHS-AS Medicaid Services Unit has developed Adult Day Health (ADH) and Assisted Living (AL) C-FQCR tools using exploratory questions as a guide for the HCB settings section of the C-FQCR tools. A C-FQCR tool was used to review Assisted Living provider settings in SFY16, while an Adult Day site visit report was used for ADH provider settings in SFY16. Updates to the Assisted Living C-FQCR tool have been made and an Adult Day Health C-FQCR tool was developed for use in SFY17 and subsequent review years. The C-FQCR tools are based on the ADvantage Program contractual documents, Oklahoma Administrative Code (OAC), Oklahoma statutes, and HCBS Final Rules. The tools are designed to measure provider compliance with defined standards and adherence to the waiver requirements, including Member choice of services and provider, training, compliance with delivery of services as authorized. As a measure to further validate findings, the tool will also survey the member's perception of service delivery performance and support to integrate into the greater community. Each SFY17 review will include a remediation plan of correction that the agency completes, as well as progress reports if there were any non-compliance issues with any of the requirements. The provider review team is responsible for monitoring and tracking the provider's progress in complying with the performance measures, HCB settings requirements, and any necessary remediation. MSU-QAI staff has received trainings provided by CMS through various webinars. MSU-QAI work is reviewed prior to final determinations being made and ongoing, with a minimum of quarterly training is provided to the MSU-QAI staff. Ongoing review staff training will be provided on the usage of the C-FQCR tool, user instructive material, policy, and CMS rules. Seasoned reviewers participate at least yearly in interrater reliability demonstration training: new reviewers are assessed more frequently at milestones in orientation training through interrater reliability activities with various reviewers. MSU-QAI and Provider staff at the ADH and AL settings have been given specific information regarding community integration requiring Members' access outside of the

facility, to avoid reverse integration (a model of intentionally inviting individuals not receiving HCBS into a facility-based setting to participate in activities with HCBS beneficiaries), to be used and considered as a sufficient strategy. It has been clearly documented that all Members must be provided opportunities to access the greater community, outside of the setting; this information is detailed in the provider-developed Community Integration Plan.

Compliance Determination

During SFY 16, HCB settings compliance was determined using a site visit report for Adult Day Health Centers and a C-FQCR tool for Assisted Living Centers. In order to be considered fully compliant, the HCBS settings score had to be 100% on the respective tool. HCBS settings scores below 100% were reviewed to designate whether the setting could comply with modifications. Non-compliance was defined as an agency that could not comply with modifications. All ADvantage agencies scoring below 100% were determined to be able to comply with minor modifications.

Individual, Private Home

The Department of Human Services Social Worker and Long Term Care (LTC) Nurse complete both financial and medical criteria, respectively, to evaluate eligibility for the ADvantage Program. A Uniform Comprehensive Assessment (UCAT Part III) is completed, in the home of each applicant by the LTC Nurse initially, then annually, or more often as needed, by the Member's Case Manager. Using the UCAT III as a tool in the home to evaluate health and safety, the LTC Nurse and Case Manager obtain information relevant in the assessment of compliance with Home and Community Based (HCBS) settings requirements including setting choice and access to the greater community including a section that asks "if you could not continue to live in your present location, do you have any ideas about where you would live?" The tool is designed to ask probing questions regarding activities of daily living (ADLs) and instrumental activities of daily living (IADLs) to aid in the development of the member driven person-centered service plan. During this initial assessment, the member chooses their desired providers and offers input to the services in their person-centered service plan. The LTC Nurse and Case Manager use the UCAT Assessor Manual to complete the form. Additionally, case management training is a requirement for ADvantage Case Management certification. A full day is devoted to the UCAT which requires the assessor to review the Member's physical and mental health, functional abilities, social supports, and physical environment documenting safety and accessibility concerns. The assessment is extensive and allows the assessor to document all observations and professional determinations regarding the appropriateness of home and community based services and settings assuring that any setting even the private home overcomes the presumptions of compliance. The UCAT addresses information regarding the owner of the applicant/Member's home. This information will be reviewed to determine if the beneficiary is living in a home owned by an unrelated, paid caregiver. If the LTC nurse, case manager, any MSU staff or provider staff finds this to be, they will be required to contact the MSU-QAI

Programs Assistant Administrator to schedule staff to evaluate the setting as a provider-owned or –controlled setting. If the member or applicant is in a setting that does not comply, the member or applicant will be advised of options of remediation, relocation to another setting, or other program options.

ICF-ID - The Oklahoma Department of Human Services (DHS), Developmental Disabilities Services Division (DDS), Quality Assurance department conducts an annual on-site performance survey with all agencies providing services through the ICF/ID Home and Community Based Waivers. Performance surveys are conducted to assess compliance with all relevant rules and policies. Performance surveys are conducted each fiscal year. The performance survey includes an evaluation of information obtained from observations, interviews with both members and providers, and records reviewed in the context of appropriate and applicable contract standards, state, and federal rules. In accordance with current ICF/ID waiver renewal language, Raosoft is used to obtain the appropriate sample size. Once the sample size is ascertained Microsoft Excel software is used to select the random sample of waiver members. The Quality Assurance department then identifies all provider agencies and setting types that coincides with the waiver member sample. Notification is given to provider agencies of when the performance survey will be completed.

The Quality Assurance department completes all performance surveys via on-site and virtual visits. The on-site visits are conducted at the individual settings where the member receives their HCB services. While the performance review is conducted at the provider agency level, assessments of all the provider's individual locations are included for every setting under the provider agency's responsibility, thereby accounting for the providers who have more than one setting. All settings that group or cluster individuals for the purpose of receiving HCBS is assessed by the state for compliance with the federal rule. Each onsite visit evaluates the criteria of each of the HCB settings requirements as reflected in the survey. Performance surveys are completed on an annual basis; however, the survey has only recently been updated to reflect the settings requirements in the HCBS Final Rule. In SFY 16, the Quality Assurance department collected the baseline data pertaining to the HCB settings requirements. The Quality Assurance department will continue to assess settings requirements in provider surveys on an annual basis hereafter. The Developmental Disability, Quality Assurance department, also conducts an area survey and has designed a Case Management Survey in an effort to further validate the Performance Survey conducted annually.

The Area survey is conducted utilizing the same representative sample reviewed for the Performance surveys. The Area survey review compliance of the HCBS settings rules as it pertains to person centered planning. Data is analyzed to reflect compliance data received and reviewed during the provider performance survey process. The Quality Assurance department has designed a new Case Management review tool that will be used annually to assess 100% of members served in the four ICF/ID waivers. The Case management review tool includes all federal HCB settings requirements. The tool is currently being completed by all case managers for SFY 17 baseline data. Beginning July 1, 2018, this tool will be completed as

part of the person-centered process for everyone receiving waiver supports. The results will become part of the recipient's record. This review tool will not only be used to validate the HCB settings but will also be used to evaluate case managements' understanding of the HCB settings rule. If needed, further training will be provided to those case managers who may not have a clear grasp of the rule. The data will be used to validate the results of the performance surveys, as they will be focused on member perception and experience with services received. The DDS Quality Assurance staff also plan to utilize the NCI data as a means of statistical validation. The staff will compare the results of this data with data gathered from the performance survey. Any statistically relevant discrepancies will be further investigated.

All new Quality Assurance staff is required to complete 60 hours of classroom training and 180 hours of on the job training that includes shadowing a senior quality assurance staff member. After the initial 180 hours of on the job training is completed, quality assurance staff participates in 8 hours of additional training with his or her supervisor. Quality assurance staff is provided quarterly training on policy and procedural updates. An annual performance survey is conducted with agencies providing services through a Home and Community Based Waiver, to assess compliance with expectations defined in the agency's contract. Microsoft Excel software is used to select the random sample of waiver members. Surveys are conducted during each state fiscal year with providers of residential, vocational, or non-medical home supports. A representative sample of service recipients from each of the four waivers is selected and then organized by provider agency who serves each service recipient included in the random sample. Notification is given to providers in the survey sample of when the survey will be completed. Surveys are completed through on-site visits. DDS ADH settings have been given specific information regarding community integration requiring member access to the greater community. ICF-ID contract provider agencies are monitored for settings compliance at least annually. The provider developed Community Integration Plan is utilized to document the opportunities given to each member. All contract provider agency that are in violation of the HCB settings requirement, are monitored at 60 day intervals until they come into compliance. Additionally, the Performance Review Committee can sanction the agency for non- compliance, limiting the agency's ability to add new members to any of the waivers and settings.

Technical assistance is provided on a regular basis by Program Managers and staff that visit each HCB settings location and review the programs to assure that these supports are providing service recipient access to the broader community. Case Managers also provide site visits for their recipients receiving Adult Day supports. These visits are recorded in the recipient's official record.

Individual, Private Home

Members who reside in individual, private homes are included in the provider survey sample universe, case managers ensure all service recipients living arrangements are monitored and updated as living arrangements change. Based on the data collected in SFY 16 and the data

collected thus far in SFY 17, it reveals that individual residences are following the HCBS Final Rule on settings. There are currently no potentials for heightened scrutiny.

Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.

NF-LOC - OHS manages a statewide complaint/concern discovery and remediation system for the Medicaid Services Unit (MSU) CareLine that offers timely response to grievances/complaints. Through a toll-free 1-800 telephone number, the Resource Center provides a centralized avenue for complaints, inquiries, or health and safety issues from Members/HCBS beneficiaries, friends, family, state agencies, providers, and the community at large. The Resource Center is designed to help safeguard the health and safety of Members/HCBS beneficiaries served through the ADvantage Program. The Resource Center receives all initial Members/HCBS beneficiaries phone inquiries, resolves routine issues, and forwards the complex or critical issues to the Escalated Issues team for research and resolution. Each complex or critical complaint call is assigned to the Escalated Issues team to research the issue and work collaboratively with all parties as needed to facilitate resolution of the issue.

As part of their orientation to the ADvantage Program, Members/HCBS beneficiaries are instructed to call the 1-800 telephone number with complaints, concerns, or requests for information. The Member/HCBS beneficiary is informed that filing a grievance or making a complaint through the Resource Center is not a pre-requisite or substitute for a Fair Hearing – that the Member/HCBS beneficiary retains, at all times, the right to request a fair hearing. However, by utilizing the 800-telephone number, resolution may be achieved without need for a fair hearing. The Resource Center utilizes a system to categorize/subcategorize complaints and identifies areas in the system for potential quality improvement activities. Escalated Issues team follows established timelines for prompt resolution depending on the category/subcategory of the issue. The Escalated Issues staff follows up on all issues until resolution is achieved.

Each ADvantage Member/HCBS Beneficiary is assigned a Case Manager that has been through specialized training to answer ADvantage program questions. At each new Member's/HCBS beneficiary orientation to the ADvantage Program, the Member's/HCBS Beneficiary chosen case manager provides in home orientation and education along with written materials to the Member and his/her selected support systems regarding the grievance process and procedures, the case management's emergency phone numbers, and the MSU CareLine 1-800 telephone number. ADvantage AL Members/HCBS Beneficiary are also provided a copy of their current Lease Agreement which includes the AL facility's grievance process and procedures and the MSU CareLine 1-800 telephone number.

ICF-ID - HCBS beneficiaries and/or guardians of HCBS beneficiaries will notify the assigned DDS Case Manager when provider non-compliance with HCBS settings regulations is suspected. The Case Manager will address beneficiary feedback by reviewing the annual

Settings Assessment and updating Settings Assessment as necessary. If the setting is out of compliance, the Case Manager will contact the provider to provide notification of the issue that is out of compliance with the HCBS settings regulations and will secure a commitment to ensure compliance, including the development a plan for correction that includes a deadline. If non-compliance with the HCBS settings regulation is not remedied by the deadline, the Case Manager will contact the DDS Case Manager Supervisor.

The Case Manager Supervisor will contact the provider's next level of oversight, provide notification of the issue, and secure a commitment to ensure compliance, including a plan for correction that includes a deadline. If non-compliance with the HCBS settings regulation is not remedied by this deadline, the Case Management Supervisor will request an Administrative Inquiry by the Quality Assurance unit (QA).

In the event the QA Administrative Inquiry is not able to remediate the issue of non-compliance, the issue is referred to the Settings Committee for recommendations to include notifying the beneficiary and provider that the setting is no longer eligible for HCBS, securing and transferring the beneficiary to an eligible setting, notifying the provider of the intent to terminate the applicable HCBS contract and taking steps to terminate the contract.

NF LOC Waivers:

Initial Compliance

The ADvantage Program certification process involves an on-site review using the Facility Evaluation tool which encompasses HCB Setting requirements and Heightened Scrutiny. The Facility Evaluation incorporates CMS Exploratory Questions, including observations and interviews, to evaluate the facility's ability to appropriately serve HCBS recipients. This process also includes a training component to review Oklahoma State Statute, Oklahoma Administrative Code, and HCBS Final Rules, with an opportunity to have questions answered. Prospective ADH & AL Providers must be found in compliance with all state & federal requirements before they are certified to provide direct services to ADvantage Members.

NF LOC Waivers:

Grievance Process

OHS manages a statewide complaint/concern discovery and remediation system for the Medicaid Services Unit (MSU) CareLine that offers timely response to grievances/complaints. Through a toll-free 1-800 telephone number, the Resource Center provides a centralized avenue for complaints, inquiries, or health and safety issues from Members/HCBS beneficiaries, friends, family, state agencies, providers, and the community at large.

The Resource Center is designed to help safeguard the health and safety of Members served through the ADvantage Program. The Resource Center receives all initial Members phone inquiries, resolves routine issues, and forwards the complex or critical issues to the Escalated Issues team for research and resolution. Each complex or critical complaint call is assigned to

the Escalated Issues team to research the issue and work collaboratively with all parties as needed to facilitate resolution of the issue.

As part of their orientation to the ADvantage Program, Members receive a welcome letter which instructs them to contact the 1-800 telephone number with complaints, concerns, or requests for information. The Member is informed that filing a grievance or making a complaint through the Resource Center is not a pre-requisite or substitute for a Fair Hearing – that the Member retains, at all times, the right to request a fair hearing; however, by utilizing the 800-telephone number, resolution may be achieved without need for a fair hearing.

As directed in the ADvantage Program Conditions of Provider Participation (COPP), each Adult Day Health, Assisted Living, Case Management, Home Care and Hospice Provider must have a written complaint and grievance process for the purpose of resolving Member complaints. A written copy of the process is given to each Member at the commencement of services and upon annual reassessment. The process includes the position/title and phone number of a Provider contact person who will be responsible for responding to such complaints and grievances. The Provider explains and discusses, with the Member, the Member's right to file a grievance. The Provider assists Members through the complaint and grievance process without reprisal or disruption of services, while continuing to treat Members with dignity and respect. The Provider also provides the telephone number for the MSU CareLine to any ADvantage Member when complaints and/or grievances cannot be resolved to the satisfaction of the Member.

Annually, the MSU Quality Assurance unit conducts audits of HCBS Providers, ensuring that documentation confirms the ADvantage Member has been given (by the Provider) a copy of the Provider's complaint and grievance process, including the name or title & phone number of the Provider contact person, as well as the phone number for the MSU Resource Center's CareLine. [1-800-435-4711]

ICF-ID LOC Waivers:

Initial Compliance

The new provider application requires the prospective provider to detail understanding of the settings rule and how they plan to incorporate the requirements into their policy, standard operating procedures and program practices. Links are provided to applicable settings statute and policy. Residential programs staff review the components of the settings rule in the onboarding process for providers who are approved and Quality Assurance staff review the components again as a separate piece of the onboarding process.

DDS Quality Assurance (QA) staff conducts annual and incident-specific on-site reviews of contracted HCBS residential and employment providers. QA staff use observation, interviews, and record reviews to determine compliance with the contract and policy

standards, including settings requirements. Any issues are discussed with the providers to ensure understanding and a report is issued to each provider agency detailing any characteristics that appear to be out of compliance with the current HCBS settings rule as part of the annual provider performance survey process. The provider must acknowledge understanding of the areas of non-compliance and are notified that a follow-up visit will be completed to confirm the issues are resolved. QA staff conduct follow-up visits until the original issue is resolved and a new sample is audited as well. This process continues until there are no deficiencies. Failure to remediate identified areas of non-compliance can result in administrative sanctions.

ICF-ID LOC Waivers:

Grievance Process

The Oklahoma Department of Human Services Office of Client Advocacy (DHS/OCA) is responsible for the operation of the grievance system.

The DHS grievance system is a multi-tiered system that affords members the opportunity to have their concerns heard and addressed beginning at the local level and continuing, through an appeals process, to the Director of DHS.

DHS/OCA has established policies that set forth the procedures to be followed as well as the timelines for each stage of the process (OAC 340:2-3-45). Notice of the member's right to file a grievance is provided upon initiation of services and annually thereafter. Timelines for response range from five working days for first level resolution to 15 days for the DHS Director's review of an appealed grievance. Each DHS/DDS Area office designates a staff person to serve as the Local Grievance Coordinator (LGC). The LGC assists members at every stage of the process and monitors each grievance filed to ensure timely and adequate response.

Grievances may be filed by any member receiving services from DHS/DDS or by anyone interested in the welfare of a member. The subject matter of the grievance may be about any policy, rule, decision, behavior, action, or condition made or permitted by DHS, its employees, or other persons authorized to provide care, including contract provider agencies and their employees.

DHS/DDS contract provider agencies are required by policy to establish a grievance process that must be approved by DHS/OCA. The process must include, at a minimum, notice of the member's right to file a grievance and to a reasonable response, timelines for response, notice of right to appeal, and the designation of a LGC who is responsible for implementation of the provider agency's grievance process.

Timelines for response to grievances range from five working days for first level resolution to ten working days for the provider agency's Board of Directors (or Appeals Committee designated by the Board).

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DHS/OCA ensures the quality of grievance systems by establishing minimum standards and through an ongoing monitoring program. The Advocate General and DHS/OCA staff have immediate and unlimited access to members, staff, and provider agency files, records, and documents relating to grievance procedures and practices.

The DHS/OCA grievance system in no way undermines the member's right to request a Fair Hearing. DHS policy provides that DHS/DDS members are granted Hearings if the application for services is denied; when resources are sufficient for initiation of HCBS waiver services and action is not taken within 45 days; or the client, family, or Guardian is aggrieved because of DHS actions to suspend, terminate, or reduce services. All other complaints or grievances are made to DHS/OCA and are addressed in accordance with DHS/OCA policies and procedures (OAC 340:2-5-61). DHS/DDS Case Managers assure that members understand that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing. Case Managers provide information annually to members, their Advocates and Guardians regarding both processes. They are also available to assist in requesting a Fair Hearing or filing a grievance.