Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: January 2, 2024

The proposed policy changes are Permanent Rules. The proposed policy changes were presented at the Tribal Consultation held on October 31, 2023. The proposed rule changes will be presented at a Public Hearing on January 8, 2024. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on January 4, 2024, and the OHCA Board of Directors on January 17, 2024.

REFERENCE: APA WF 23-25B

SUMMARY:

Advantage and State Plan Personal Care Revisions - The proposed rule revisions for the 1915(c) Home and Community Based Services (HCBS) ADvantage Waiver program and State Plan Personal Care Services seek to remove outdated processes, reduce unnecessary timeline and procedural burdens, clarify modalities used in medical eligibility assessments, and match recent system changes. Proposed revocations remove individual personal care assistants (IPCA) which are no longer used in these programs. Resumption of services information is removed from the closure section to reduce duplication. Proposed revisions also add Living Choice as a referral option when appropriate and provide general cleanup to the language.

LEGAL AUTHORITY:

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 1915(c) of the Social Security Act

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 23-25B

A. Brief description of the purpose of the rule:

The proposed revisions are requested following an extensive review of rules related to ADvantage and State Plan Personal Care in Chapters 30 and 35 of Title 317. Updates are needed to remove outdated processes, to reflect current processes and systems, to add clarity and correct references, and to reduce burdensome timelines for case management requirements as appropriate.

B. A description of the classes of persons who most likely will be affected by the proposed rule,

including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

Recipients and providers of ADvantage Waiver services and State Plan Personal Care services will be affected by the timeline changes. This rule should not place any cost burden on public or private entities. No information on any cost impacts were received from any entity. This rule should not place any cost burden on public or private entities. No information on any cost impacts were received from any entity.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes will benefit providers of ADvantage Waiver services and State Plan Personal Care services. The proposed changes will also benefit recipients of those services, and agency oversight and management of those services.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

Agency staff has determined that the proposed changes are budget neutral.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The Agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety, and environment if the proposed rule is not implemented:

The Agency does not anticipate any detrimental effect on the public health, safety, or environment if the proposed rule changes are not implemented.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: October 19, 2023

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 15. STATE PLAN PERSONAL CARE SERVICES

317:35-15-2. State Plan Personal Care (SPPC) services

(a) SPPC services assist a member in carrying out Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs. SPPC services prevent or minimize physical health regression or deterioration. SPPC services require a skilled nursing assessment to:

(1) Assess a member's needs;
(2) Develop a care plan to meet the member's identified personal care needs;
(3) Manage care plan oversight; and
(4) Periodically reassess and update the care plan when necessary.

(b) SPPC services do not include technical services, such as:

(1) Suctioning;
(2) Tracheal care;
(3) Gastrostomy-tube feeding or care;
(4) Specialized feeding due to choking risk;
(5) Applying compression stockings;
(6) Bladder catheterization;
(7) Colostomy irrigation;
(8) Wound care;
(9) Applying prescription lotions or topical ointments;
(10) Range of motion exercises; or

(11) Operating equipment of technical nature, such as a patient lift or oxygen equipment.

(c) SPPC members may receive services in limited types of living arrangements as per (1) through (5) of this subsection.

(1) SPPC members are not eligible to receive services while residing in an institutional setting including, but not limited to:

(A) Licensed facilities, such as a:

(i) Hospital;

(ii) Nursing facility;

(iii) Licensed residential care facility; or

(iv) Licensed assisted living facility; or

(B) In an unlicensed institutional living arrangement, such as a room and board home or facility.

(2) SPPC is not approved when the member lives in the personal care assistant's (PCA) ~~or the individual personal care assistant's (IPCA)~~ home, except with Oklahoma Human Services (OKDHS) Medicaid Services Unit approval.

(3) Members may receive SPPC services in the member's own home, apartment, or a family member's or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit including a bathroom and food storage and preparation amenities in addition to bedroom and living space.

(4) For SPPC members who are full-time students, a dormitory room qualifies as an allowable living arrangement to receive SPPC services.

(5) With prior OKDHS Health Care Management Nurse III approval, SPPC services may be provided in an ~~educational or~~ employment setting to assist the member to achieve vocational goals identified in the care plan.

(d) ~~A member may employ an IPCA to provide SPPC services. An IPCA may provide SPPC services when he or she is employed by a home care agency, provided the home care agency is certified and contracted with the Oklahoma Health Care Authority (OHCA) to provide SPPC services. Before providing SPPC services, OKDHS determines whether the IPCA is qualified to provide personal care services and the IPCA is not identified as formal or informal support for member.~~ Persons eligible to serve as ~~either IPCAs or~~ PCAs:

(1) Are at least eighteen (18) years of age;

(2) Have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;

(3) Are not included in the OKDHS Community Services Worker Registry;

(4) Are not convicted of a crime and do not have a criminal background history or registry listings that ~~prohibit~~prohibits employment per Title 63 of the Oklahoma Statutes Section 1-1944 through ~~1-948~~1-1948;

(5) Demonstrate the ability to understand and carry out assigned tasks;

(6) Are not a legally responsible family member of the member being served, such as a spouse, legal guardian, or a minor child's parent;

(7) Have a verifiable work history or personal references, and verifiable identification; and

(8) Meet any additional requirements outlined in the contract and certification requirements with OHCA.

(e) SPPC services eligibility is contingent on a member requiring one (1) or more of the services offered at least monthly including personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet ADL or IADL assessed needs.

317:35-15-4. State Plan Personal Care (SPPC) services medical eligibility determination

(a) **Eligibility.** The Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) III determines medical eligibility for SPPC services based on the Uniform Comprehensive Assessment Tool (UCAT) and the determination that the member has unmet care needs that require personal care assistance. SPPC services are initiated to support the regular care provided in the member's home. SPPC services are not intended to take the place of regular care, general maintenance tasks, or meal preparation provided by natural supports, such as spouses or other adults who live in the same household. Additionally, SPPC services are not furnished when they principally benefit the family unit. To be eligible for SPPC services, the applicant:

(1) Has adequate informal supports. This means there is adult supervision that is present or available to contribute to care, or decision-making ability, as documented on the UCAT. To remain in his or her home without risk to his or her health, safety, and well-being, the applicant:

(A) Has the decision-making ability to respond appropriately to situations that jeopardize his or her health and safety, or has available supports that compensate for his or her lack of ability as documented on the UCAT; or

(B) Has his or her decision-making ability, lacks the physical capacity to respond appropriately to situations that jeopardize health and safety, and an OKDHS HCMN I or II informed him or her of potential risks and consequences of remaining in the home.

(2) Requires a care plan for planning and administering services delivered under a professional personnel's supervision;

(3) Has a physical impairment or combination of physical and mental impairments as documented on the UCAT. An applicant who poses a threat to himself or herself or others, as supported by professional or credible documentation, may not be approved for SPPC services. An individual who is actively psychotic or believed to be in danger of potential harm to himself or herself or others may not be approved;

(4) Does not have household members or persons who routinely visit the household who, as supported by professional or credible documentation, pose a threat of harm or injury to the applicant or other household visitors;

(5) Lacks the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) Requires assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(b) **Definitions.** The following words and terms, when used in this subsection, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Activities of Daily Living" (ADL)** means activities that reflect the applicant's or member's ability to perform self-care tasks essential for sustaining health and safety, such as:

(A) Bathing;

(B) Eating;

(C) Dressing;

(D) Grooming;

(E) Transferring, including activities such as getting in and out of a tub or moving from bed to chair;

(F) Mobility;

(G) Toileting; and

(H) Bowel or bladder control.

(2) **"ADLs score of three (3) or greater"** means the applicant or member cannot do at least one (1) ADL at all or needs some help with two (2) or more ADLs.
(3) **"Applicant or Member support very low"** means the applicant's or member's UCAT Support score is zero (0), this indicates, in the UCAT assessor's clinical judgment, the formal and informal sources are sufficient for the applicant's or member's present need level in most functional areas.
(4) **"Applicant or Member support low"** means the member's UCAT Support score is five (5), this indicates, in the UCAT assessor's clinical judgment, the support from formal and informal sources are nearly sufficient for the applicant's or member's present need level in most functional areas. The applicant or member, family, or informal supports are meeting most needs typically expected of family or household members to share or do for one another, such as general household maintenance. There is little risk of institutional placement with loss of current supports.
(5) **"Applicant or Member support moderate"** means the UCAT applicant or member score is fifteen (15), this indicates, in the UCAT assessor's clinical judgment, the formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The applicant or member requires additional assistance that usually includes personal care assistance with one (1) or more ADLs not available through Medicare, the Veterans Administration, or other federal entitlement programs. Informal caregiver support is considered questionable or unreliable due to one (1) or more criteria in (A) through (D) of this paragraph:
(A) Care or support is required continuously with no relief or backup available;
(B) Informal support lacks continuity due to conflicting responsibilities such as work or child care;
(C) Persons with advanced age or disability provide care; or
(D) Institutional placement can reasonably be expected with any loss of existing support.
(6) **"Applicant or Member support high"** means the applicant or member score is twenty-five (25) this indicates, in the UCAT assessor's clinical judgment, the formal and informal supports are not sufficient as there is very little or no support available to meet the applicant's or member's high degree of need.
(7) **"Community Services Worker"** means any non-licensed health professional employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities.
(8) **"Community Services Worker Registry"** means an OKDHS established registry established by the OKDHS per Section ~~(')~~(§) ~~1025.1~~1025.3 of Title 56 of the Oklahoma Statutes (O.S.) listing community services workers who have a final investigative finding of abuse, neglect, or exploitation, per 43A O.S. ~~'~~§10-103, involving a frail elderly person, or person(s) with developmental or other disabilities was made by OKDHS or an administrative law judge.
(9) **"Instrumental Activities of Daily Living (IADL)"** means those daily activities that reflect the applicant or member's ability to perform household chores and tasks within the community essential for sustaining health and safety, such as:
(A) Shopping;
(B) Cooking;
(C) Cleaning;
(D) Managing money;

(E) Using a phone;
(F) Doing laundry;
(G) Taking medication; and
(H) Accessing transportation.

(10) **"IADLs score is at least six (6)"** means the applicant or member needs some help with at least three (3) IADLs or cannot do two (2) IADLs at all.

(11) **"IADLs score of eight (8) or greater"** means the applicant or member needs some help with at least four (4) IADLs or the member cannot do two (2) IADLs at all and needs some help with one (1) or more other IADLs.

(12) **"MSQ"** means the Mental Status Questionnaire.

(13) **"MSQ moderate risk range"** means a total weighted-score of seven (7) to eleven (11) that indicates an orientation-memory-concentration impairment or memory impairment.

(14) **"Nutrition moderate risk"** means a total weighted UCAT Nutrition score is eight (8) or greater that indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

(15) **"Social Resource score is eight (8) or more"** means the applicant or member lives alone, has no informal support when he or she is sick or needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for SPPC.** The medical eligibility minimum criteria for SPPC services are the minimum UCAT score criteria that an applicant or member meets for medical eligibility and are:

(1) ADLs score is five (5) or greater; or has an IADLs score of eight (8) or greater; or Nutrition score is (8) or greater; or the MSQ score is seven (7) or greater; or the ADLs score is three (3) and IADLs score is at least six (6); and

(2) Applicant or Member Support score is fifteen (15) or more; or Applicant or Member Support score is five (5) and the Social Resources score is eight (8) or greater.

(d) **Medical eligibility determination.** OKDHS HCMN III determines medical eligibility for SPPC services utilizing the UCAT.

(1) Categorical relationship is established for SPPC services financial eligibility determination.

(A) When categorical relationship to Aid to the Disabled is not established, but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination.

(B) When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1.

(C) The licensed health care professional cannot be in a medical facility internship, residency, or fellowship program or in the full-time employment of the Veterans Administration, United States Public Health Service, or other agency.

(D) The OKDHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a medical eligibility determination for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA) definition. The OKDHS county worker is required to conduct a follow-up with SSA to ensure the SSA disability decision is also the LOCEU decision.

(2) Approved contract agencies or the ADvantage Administration (AA) may complete the electronic application. This alerts the social services specialist (SSS) of application date.

(3) Upon referral receipt, OKDHS SSS starts the financial eligibility determination.
(4) The OKDHS HCMN I or II is responsible for completing the UCAT assessment visit within ten (10) business days of the ~~personal care~~in-home application for the applicant who is SoonerCare eligible at the time of the request. The OKDHS HCMN I or II completes the assessment visit within twenty (20) business days of the referral for the applicant not determined SoonerCare eligible at the time of the request. When the application indicates the request is from an individual who resides at home and an immediate response is required to ensure the applicant's health and safety, to prevent an emergency situation~~,~~ or to avoid institutional placement, the UCAT assessment visit has top-scheduling priority.

(A) For initial level of care (LOC) for applicants younger then eighteen (18) years of age, the OKDHS nurse assesses applicants through a face-to-face visit using the UCAT.

(B) For initial LOC for applicants eighteen (18) years of age or older, the OKDHS nurse assesses applicants through electronic format, such as phone or video conference, using the UCAT unless there are limiting factors which necessitate a face-to-face assessment.

(i) The OKDHS nurse determines LOC based upon the assessment outcome unless the applicant is medially ineligible. In this case, a face-to-face visit is scheduled to either validate the initial electronic format assessment or to provide additional documentation to support the applicant meeting medical LOC.

(ii) Applicants are not medically denied access to services solely based on the assessment completed through an electronic format.

(5) During the assessment visit, the OKDHS HCMN I or II completes the UCAT and reviews rights to privacy, fair hearing, provider choice, and the pre-service acknowledgement agreement with the member. The OKDHS HCMN I or II gives the applicant information about medical eligibility criteria and OKDHS long-term care service options. OKDHS HCMN I or II documents if the member wants to be considered for nursing facility level of care services or if the member is applying for a specific service program on the UCAT. When, based on the information obtained during the assessment, the OKDHS HCMN I or II determines if the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services or Child Protective Services, as applicable. The referral is documented on the UCAT.

(A) When SPPC services are not sufficient to meet the applicant's or member's needs, the OKDHS HCMN I or II provides information about other community long-term care service options. The OKDHS HCMN I or II assists in accessing service options applicant or member selects in addition to, or in place of, SPPC services.

(B) When multiple household members are applying for SoonerCare SPPC services, the UCAT assessment is done for all the household members at the same time.

(C) The OKDHS HCMN I or II provides the applicant or member with information about the qualified agencies in his or her local area that provide services and obtains the applicant's or member's primary and secondary agency choice. When the applicant or family declines to choose a primary personal care service agency, the round-robin rotation system is used for agency selection. The OKDHS HCMN I or II documents the selected personal care provider agency's name.

(6) The OKDHS HCMN I or II completes the UCAT in the electronic system~~,~~ and the OKDHS HCMN III makes the medical eligibility determination. SPPC service eligibility is established on the date medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) When the time length from the initial assessment to the date of service eligibility

determination exceeds ninety (90) calendar days, a new UCAT assessment is required.

(B) The OKDHS HCMN III assigns a medical certification period of not more than thirty-six (36) months for persons eighteen (18) years of age and older or not more than twelve (12) months for persons younger than eighteen (18) years of age. The service plan period is for twelve (12) months.

(7) The SSS is notified via the electronic system of the personal care certification.

(8) Upon establishing SPPC certification, the OKDHS HCMN I or II notifies the applicant's or member's preferred provider agency, or when necessary, the secondary provider agency or the provider agency selected by the round robin rotation system. Within one (1) business day of provider agency acceptance, the OKDHS HCMN I or II submits the information via electronic system to the provider agency for plan development. Refer to OAC 317:35-15-8(a).

(9) Following the provider agency's SPPC plan development, and within three (3) business days of receipt from the provider agency, the OKDHS HCMN I or II reviews the documentation to ensure agreement with the plan. Once agreement is established, the plan is authorized or submitted to the OKDHS HCMN III for review.

(10) Within ten (10) business days of the SPPC plan receipt from the OKDHS HCMN I or II, the OKDHS HCMN III authorizes or denies the plan units. If the plan fails to meet standards for authorization, it is returned to the OKDHS HCMN I or II for further justification.

(11) Within one (1) business day of knowledge of the authorization, the OKDHS HCMN I or II submits the plan authorization to the provider agency via electronic system.

317:35-15-8. Agency State Plan Personal Care (SPPC) service authorization and monitoring

(a) Within ten (10) business days of referral receipt for SPPC services, the personal care provider agency nurse completes an assessment of the member's personal care service needs and completes and submits a person-centered plan based on the member's needs to the Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) I or II. The plan includes the:

(1) Adv/SPPC-Nurse Evaluation;

(2) SPPC-Service Planning; and

(3) SPPC Member Service Agreement.

(b) When more than one (1) person in the household is referred to receive SPPC or ADvantage services, all household members' plans are discussed and developed with the eligible members, so service delivery is coordinated to achieve the most efficient use of resources. The number of SPPC service units authorized for each individual is distributed between all eligible family members. This ensures one (1) family member's absence does not adversely affect the family member(s) remaining in the home. When one (1) or more persons in the same household with a SPPC member is referred to or receives other formal services, such as ADvantage or Developmental Disability Services, then those services are coordinated as well.

(c) The personal care provider agency receives documentation from the OKDHS HCMN I or II for authorization to begin services. The agency provides a copy of the plan to the member upon initiating services.

(d) Prior to the provider agency placing a Personal Care Assistant (PCA) in the member's home or other service-delivery setting, an Oklahoma State Bureau of Investigation background check, an Oklahoma State Department of Health Registry check, and an OKDHS Community Services Worker Registry check is completed per Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide SPPC services and meet ~~criteria~~ Oklahoma Administrative Code (OAC) 317:35-15-2~~(c)~~(d) (1) through (8) criteria.

(e) The provider agency nurse monitors the member's care plan.

(1) The personal care provider agency nurse or staff contacts the member within five (5) business days of authorized document receipt ~~in order~~ to ensure services are implemented according to the authorized care plan.

(2) The provider agency nurse makes a monitoring visit using the Adv/SPPC Nurse Evaluation at least every six (6) months to assess the member's satisfaction with his or her care and to evaluate the care plan for adequacy of goals and authorized units. Whenever a monitoring visit is made, the provider agency nurse documents findings in the electronic system. The provider agency submits monitoring documentation to the OKDHS HCMN I or II for review within five (5) business days of the visit. A registered nurse (RN) conducts the monitoring visit when the PCA is performing hands-on personal care. A licensed practical nurse may only conduct the monitoring visit when the PCA is not performing hands-on personal care. An RN also co-signs the progress notes.

(3) The provider agency nurse's requests to change the number of authorized units in the SPPC plan are submitted via the electronic system to the OKDHS HCMN III to approve or deny prior to changed number of authorized units implementation.

(4) Annually, or more frequently when the member's needs change, the provider agency nurse re-assesses the member's needs and develops a new plan to meet the member's needs. The provider agency nurse completes and submits the annual reassessment documents to the OKDHS HCMN I or II no sooner than sixty (60) calendar days before the existing service plan end-date, and no later than fourteen (14) calendar days prior to service.

(5) When the member is unstaffed, the provider agency nurse or staff communicates with the member and makes efforts to re-staff. When consecutively unstaffed for seven (7) calendar days, or fewer depending on the member's needs, the provider agency nurse or staff contacts the unstaffed member weekly by phone to actively monitor the member's health and safety and documents ongoing efforts to provide staff using the electronic system. When the member is unstaffed for thirty (30) days, the provider agency notifies the OKDHS HCMN I or II via the Case Note for SPPC thirty (30) day unstaffed note in the electronic system. The HCMN I or II contacts the member and when the member chooses, initiates a member transfer to another provider agency that can provide staff.

317:35-15-8.1. Agency State Plan Personal Care services; billing, and problem resolution

The ADvantage Administration (AA) certifies qualified personal care provider agencies and facilitates the execution of the agencies' SoonerCare (Medicaid) contracts on the Oklahoma Health Care Authority's (OHCA) behalf. OHCA checks the list of providers barred from Medicare/SoonerCare (Medicaid) participation to ensure that the personal care services agency is not listed.

(1) **Payment for State Plan Personal Care (SPPC).** Payment for SPPC services is made for care provided in the member's own home or in other limited living arrangement types, per Oklahoma Administrative Code (OAC) 317:35-15-2~~(b)~~(c) (1 through ~~4~~5).

(A) **Provider agency use.** To provide SPPC services, an agency must be licensed by the Oklahoma State Department of Health, meets certification standards identified by Oklahoma Human Services (OKDHS), and possesses a current SoonerCare (Medicaid) contract.

(B) **Reimbursement.** SPPC services payment on a member's behalf is made according to the service type and number of authorized service units.

(i) The amount paid to provider agencies for each service unit is determined according to established SoonerCare (Medicaid) rates for the personal care services. Only authorized units contained in each eligible member's individual plan are eligible for reimbursement. Provider agencies serving more than one member residing in the same residence ensure the members' plans combine units in the most efficient manner to meet the needs of all eligible persons in the residence.

(ii) SPPC services payment is for tasks performed in accordance with the authorized care plan per OAC 317:30-5-951. Payment for personal care skilled nursing service is made on the member's behalf for assessment, evaluation, and associated service planning per nursing visit.

(iii) SPPC service time is documented through the Electronic Visit Verification System (EVV), previously known as Interactive Voice Response Authentication (IVRA) system, when services are provided in the home.

(2) **Issue resolution.**

(A) The provider agency provides a written copy of their grievance process to each member at service commencement. The written grievance process includes the name and phone number of a provider agency contact person who is responsible for responding to such complaints and grievances. When the member is dissatisfied with the SPPC provider agency or the assigned PCA and has exhausted attempts to work with the agency's grievance process without resolution, the member is referred to the OKDHS State Plan Care Unit to attempt to resolve the issue(s). The member has the right to appeal to OHCA per OAC 317:2-1-2.

(B) When a PCA performance issue is identified, provider agency staff conducts a counseling conference with the member or the PCA as appropriate. Provider agency staff counsels the PCA regarding problems with his or her performance.

(3) **Persons ineligible to serve as a PCA.** Payment from SoonerCare funds for SPPC services may not be made to an individual who is a legally responsible family member of the member, such as a spouse, legal guardian, or parent of a minor child, when he or she is providing SPPC services.

317:35-15-10. Medical eligibility redetermination for State Plan Personal Care (SPPC) services

(a) **Medical eligibility redetermination.** The Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) III completes a medical redetermination before the end of the long-term care medical certification period.

(b) **Recertification.** The OKDHS HCMN I or II re-assesses the SPPC service members ~~eighteen (18) years of age and older,~~ for medical re-certification based on the member's needs and level of caregiver support required, using the Uniform Comprehensive Assessment Tool (UCAT) ~~at least every thirty-six (36) months. Members younger than eighteen (18) years of age, are re-evaluated by the OKDHS HCMN I or II using the UCAT on a twelve (12) month basis or sooner when needed~~. During this re-certification assessment, the OKDHS HCMN I or II informs the member of the state's other SoonerCare (Medicaid) long-term care options. The OKDHS HCMN I or II submits the re-assessment to the OKDHS HCMN III for recertification. Documentation is sent to the OKDHS area nurse no later than the tenth (10^{th}) calendar day of the month certification expires. When the OKDHS HCMN III determines medical eligibility for SPPC services, a recertification review date is entered on the system.

(1) Members younger than eighteen (18) years of age are re-evaluated through a face-to-face visit by the OKDHS HCMN I or II using the UCAT on a twelve (12) month basis or sooner when needed.

(2) Members eighteen (18) years of age and older are re-evaluated by the OKDHS HCMN I or II using the UCAT at least every thirty-six (36) months through an electronic format, such as a phone or video conference, using the UCAT unless there are limiting factors which necessitate a face-to-face assessment.

(A) The OKDHS nurse determines level of care (LOC) based on the assessment's outcome unless the member is determined to be medically ineligible. In this case, a face-to-face visit is scheduled to either validate the electronic format assessment or provide additional documentation to support the member meeting medical LOC.

(B) Members are not medically denied access to services solely based on an assessment completed through an electronic format.

(c) **Change in amount of units or tasks.** When the SPPC provider agency determines a need for a change in the amount of units or tasks in the service, a care plan is completed and submitted to OKDHS within five (5) business days of identifying the assessed need. The OKDHS HCMN III approves or denies the change prior to implementation.

(d) **SPPC services voluntary closure.** When a SPPC member decides personal care services are no longer needed to meet his or her needs, a medical decision is not needed. The member is sent a Voluntary Withdrawal Request for confirmation and signature, and the request is entered into the electronic system upon receipt. A closure notification is submitted to the provider agency via the electronic system.

(e) **Resuming personal care services.** When a SPPC member approved for SPPC services is without services for less than ninety (90) calendar days, but the member has current medical and SoonerCare (Medicaid) financial eligibility approval, SPPC services may be resumed using the member's previously approved plan. The personal care provider agency nurse contacts the member to determine when changes in health or service needs occurred. When changes are identified, the provider agency nurse completes an assessment visit and submits a SPPC services skilled nursing need re-assessment within ten (10) business days of the resumed plan start date. When the member's needs dictate, the personal care provider agency may submit a request for a change in authorized SPPC service units. When no changes occur, the agency nurse documents the contact in the electronic system for the OKDHS HCMN I or II ten (10) business days ~~of~~before the resumed plan start date.

(f) **Financial ineligibility.** When the OKDHS social services specialist (SSS) determines a member does not meet SoonerCare (Medicaid) financial eligibility criteria, the OKDHS HCMN III is notified to initiate the closure process due to financial ineligibility. When OKDHS determines a member to be financially ineligible for SPPC services, they notify the member of the determination, and his or her right to appeal the decision in writing. A closure notification is submitted to the provider agency.

(g) **Closure due to medical ineligibility.** When OKDHS determines a member to be medically ineligible for SPPC services, they notify the member of the determination, and his or her right to appeal the decision, in writing. When medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until care level redetermination is established. For members:

(1) Who are not hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for a maximum sixty (60) calendar days from the date of the previous medical eligibility expiration date;

(2) Who are hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for thirty (30) calendar days from the date of discharge from the facility or for sixty (60) calendar days from the date of previous medical eligibility expiration date, whichever is longer;

(3) Whose medical eligibility redetermination is not made by applicable extended deadline, the member is determined to be medically ineligible; or

(4) Who no longer meet medical eligibility or cannot be located to complete the redetermination assessment, the HCMN I or II notifies the HCMN III. The HCMN III updates the system's medical eligibility end date and notifies the HCMN I or II of the effective end date. A closure notification is submitted to the provider agency.

(h) **State Plan Personal Care services termination.**

(1) State Plan Personal Care (SPPC) services may be discontinued when:

(A) Professional documentation supports the member poses a threat to self or others;

(B) Other household members or persons who routinely visit the household who, as professional or credible documentation supports, pose a threat to the member or other household visitors;

(C) The member or the other household members use threatening, intimidating, degrading, or sexually inappropriate language or innuendo or behavior towards service providers, either in the home or through other contact or communications. Efforts to correct such behavior are unsuccessful as professional or credible documentation supports;

(D) The member or family member fails to cooperate with SPPC service delivery or to comply with Oklahoma Health Care Authority ~~(OHCA)~~ or OKDHS rules as professional or credible documentation supports;

(E) The member's health or safety is at risk as professional or credible documentation supports;

(F) Additional services, either "formal" such as, paid by Sooner Care (Medicaid) or some other funding source or "informal" such as, unpaid are provided in the home. This eliminates the need for SoonerCare SPPC services;

(G) The member's living environment poses a physical threat to self or others as professional or credible documentation supports, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible; or

(H) The member refuses to select or accept a provider agency or Personal Care Assistant (PCA) service for ninety (90) consecutive days as professional or credible documentation supports.

(2) For members receiving SPPC services, the provider agency submits documentation with the recommendation to discontinue services to OKDHS. The OKDHS HCMN I or II reviews the documentation and submits it to the OKDHS HCMN III for determination. The personal care provider agency or PCA and the local OKDHS social services specialist ~~is~~are notified of the decision to terminate services via the electronic system. The member is sent an official closure notice informing him or her of appropriate member rights to appeal the decision to discontinue services.

317:35-15-13.1. Individual personal care assistant (IPCA) service management [REVOKED]

~~(a) An Individual Personal Care Assistant (IPCA) may be utilized to provide SPPC services when it is documented to be in the member's best interest to have an IPCA, or when there are no qualified personal care provider agencies available in the member's local area. Oklahoma Health Care~~

Authority (OHCA) checks the list of providers barred from Medicare/Medicaid participation to ensure the IPCA is not listed.
(b) After SPPC services eligibility is established, and prior to implementation of SPPC services using an IPCA, the OKDHS Health Care Management Nurse I or II reviews the care plan with the member and IPCA and notifies them to begin SPPC services delivery. The OKDHS HCMN I or II maintains the original care plan and forwards a copy to the selected IPCA and member within one (1) business day of approval receipt.
(c) The HCMN I or II contacts the member within five (5) business days to ensure services are in place and meeting the member's needs. The HCMN I or II also monitors the care plan for members with an IPCA. For any member receiving SPPC services utilizing an IPCA, the OKDHS HCMN I or II makes a home visit at least every six (6) months beginning within ninety (90) calendar days from the date of service initiation. OKDHS HCMN I or II assesses the member's satisfaction with his or her SPPC services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan are approved by the HCMN III prior to implementation.

317:35-15-13.2. Individual personal care assistants (IPCA) provider contractor; billing, training, and problem resolution [REVOKED]

While the Oklahoma Health Care Authority (OHCA) is the contractor authorized under federal law, the Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) I or II initiates initial contracts with eligible members to provide SPPC services per Oklahoma Administrative Code (OAC) 317:35-15-2. OHCA is responsible for IPCA contract renewal.

(1) **IPCA payment.** Payment for SPPC services is made for care provided in the member's own home or in other limited types of living arrangements per OAC 317:35-15-2(b)(1) through (4). SPPC services may not be approved when the member lives in the Personal Care Assistant's (PCA) home, except with the approval of OKDHS Community Living, Aging and Protective Services.

(A) **Reimbursement**. Personal care payment for a member is made according to the number of personal care units identified in the service plan.

(i) The amount per unit paid to individual contractors is determined according to the established rates. A service plan is developed for each member in the home and service units are assigned to meet each member's needs. The service plans combine units efficiently to meet all eligible members needs in the household.

(ii) From the total amounts the IPCA bills in (i) of this subparagraph, OHCA, acting as agent for the member-employer, withholds the appropriate FICA tax percentage and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To ensure the Social Security account is credited, the individual contractor's Social Security number is entered correctly on each claim.

(iii) The contractor payment fee covers all SPPC services included on the service and care plans the OKDHS HCMN I or II develops. Payment is only made for eligible members' direct services and care. The OKDHS HCMN III, authorizes the number of service units the member receives.

(iv) A member may select more than one (1) IPCA. The service and care plan indicates when this is necessary.

(v) The IPCA may provide SoonerCare SPPC services for several households during one (1) week as long as the daily number of paid service units does not exceed eight

(8) hours, thirty-two (32) units per day. Total weekly hours cannot exceed forty (40), one-hundred and sixty (160) units.

(B) **IPCA wage or employment information release.** Any inquiry received by the local office requesting wage or employment information is forwarded to OHCA, Claims Resolution.

(2) **IPCA member selection**. Members or family members recruit, interview, conduct reference checks, and select applicants for IPCA consideration. Prior to placing an IPCA in the member's home, an Oklahoma State Bureau of Investigation (OSBI) background check and an OKDHS Community Services Worker Registry check are completed per Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes (O.S. 63 '' 1-1944 through 1-948). The OKDHS HCMN I or II also checks the Certified Nurse Aide Registry. The OKDHS HCMN I or II affirms the applicant's name is not contained on any of the registries. The OKDHS HCMN I or II notifies OHCA when the applicant is on any registry.

(A) **Persons eligible to serve as IPCAs.** SPPC services payment is made IPCAs who meet the criteria per OAC 317:35-15-2(c)(1) through (8).

(B) **Persons ineligible to serve as IPCAs.** SPPC services payment from SoonerCare funds may not be made to an individual who is the member's legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served.

(i) Payment cannot be made to or an OKDHS or OHCA employee. Payment cannot be made to an immediate family member of a an OKDHS employee who works in the same county without OKDHS Medicaid Services Unit approval. When a family member relationship exists between an OKDHS HCMN I or II and an IPCA in the same county, the OKDHS HCMN I or II cannot manage services for a member whose IPCA is his or her family member.

(ii) If it is determined that an OKDHS HCMN I or II or an OHCA employee is interfering in service provision for personal or family benefit, the employee is subject to disciplinary action.

(3) **IPCA orientation.** When a member selects an IPCA, the OKDHS HCMN I or II notifies the selected IPCA to complete the Oklahoma State Department of Health (OSDH) Form 805, Uniform Employment Application for Nurse Aide Staff, and the OKDHS Form 06PE039E, Employment Application Supplement, and for a qualification determination and orientation determination. For SPPC members, this process is the OKDHS HCMN I or II responsibility. The IPCA can begin work after:

(A) The member interviews him or her;

(B) The OKDHS nurse orients him or her;

(C) A contract (OHCA-0026) is executed with the OHCA;

(D) The effective service date is established;

(E) All registries are checked and the IPCA's name is not listed;

(F) OSDH Nurse Aide Registry is checked and no notations are found; and

(G) OSBI background check is completed.

(4) **IPCA training.** It is the OKDHS HCMN I or II responsibility to make sure the IPCA has the training needed to carry out the care plan prior to each member's service initiation.

(5) **Problem resolution related to IPCA performance**. When it comes to the OKDHS HCMN I or II attention there is a problem related to IPCA performance, a counseling conference is held between the member, OKDHS HCMN I or II, and IPCA. The OKDHS HCMN I or II counsels the IPCA regarding problems with his or her performance when doing so results in improved

~~performance.~~

~~(6) **IPCA Provider Agreement termination.**~~

~~(A) An IPCA contract termination recommendation is submitted to OHCA and IPCA services are suspended immediately when the IPCA:~~

~~(i) Performance poses a threat to the member's health and safety or to others; or~~

~~(ii) Failed to comply with PCA Provider Agreement expectations and counseling is not appropriate or effective; or~~

~~(iii) Name appears on the OKDHS Community Services Worker Registry or any registry listed in O.S. 63 ' 1-1947, even when his or her name is not on the registry at the time of application or hiring.~~

~~(B) The OKDHS HCMN makes the IPCA termination recommendation to OKDHS Community Living, Aging and Protective Services Medicaid Services Unit (MSU), MSU then notifies the OHCA Legal Division of the recommendation. When the problem is related to abuse, neglect, or exploitation allegations OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, OHCA, and OSDH are notified.~~

~~(C) When the problem is related to abuse, neglect, or exploitation allegations, the OKDHS HCMN follows the process, per OAC 340:100-3-39.~~

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-2. Level of care medical eligibility determination

The Oklahoma Human Services (OKDHS) area nurse, or nurse designee, determines medical eligibility for ADvantage program services based on the Uniform Comprehensive Assessment Tool (UCAT) ~~III~~ assessment and the determination that the member has unmet care needs that require ADvantage or ~~NF~~nursing facility (NF) services to assure member health and safety. ADvantage services are initiated to support the informal care that is being provided in the member's home, or, that based on the UCAT, can be expected to be provided in the ~~members's~~member's home upon discharge of the member from a NF or hospital. These services are not intended to take the place of regular care and general maintenance tasks or meal preparation typically shared or done for one another by spouses or other adults ~~and~~ who live in the same household. Additionally, services are not furnished if they principally benefit the family unit. When there is an informal (not paid) system of care available in the home, ADvantage service provision will supplement the system within the limitations of ADvantage Program policy to enable the family and/or significant others to continue caregiving over extended periods. ~~When the ADvantage personal care attendant and member live within the same household, personal care will only be approved by agreement of the interdisciplinary service planning team and OKDHS AA approval that the personal care tasks are consistent with plan goals and have beneficial outcomes for the member.~~

(1) **Definitions**. The following words and terms when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

(A) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

(i) bathing,

(ii) eating,

(iii) dressing,

(iv) grooming,

(v) transferring (includes getting in and out of a tub, bed to chair, etc.),
(vi) mobility,
(vii) toileting, and
(viii) bowel/bladder control.

(B) **"ADLs score in high risk range"** means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

(C) **"ADLs score at the high end of the moderate risk range"** means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

(D) **"Client Support high risk"** means member's UCAT Client Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the overall total support is entirely inadequate to meet a high degree of medically complex needs. Functional capacity is so limited as to require full time assistance and the stability of the care system is likely to fail. The member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs to prevent an imminent risk of ~~life threatening~~life-threatening health deterioration or institutional placement.

(E) "**Client Support low risk"** means member's UCAT Client Support score is 5 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is nearly sufficient/stable with minimal or few needs for formal services (i.e., some housekeeping only). The member/family/informal supports are meeting most needs typically expected for family/household members to share or do for one another, i.e., general household maintenance. There is little risk of institutional placement even with a loss of current supports.

(F) **"Client Support moderate risk"** means member's UCAT Client Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that usually includes personal care assistance with one or more activity of daily living tasks and is not available through Medicare, Veterans Administration, or other federal entitlement programs. Support provided by informal caregivers is of questionable reliability due to one or more of the following:

(i) Care/support is required continuously with no relief or backup available, or
(ii) Informal support lacks continuity due to conflicting responsibilities such as job and/or child care, or
(iii) Care/support is provided by persons with advanced age and/or disability, and
(iv) Institutional placement can reasonably be expected with any loss of existing support.

(G) **"Cognitive Impairment"** means that the individual, as determined by the clinical judgment of the OKDHS Nurse or the AA, does not have the capability to think, reason,

remember or learn skills required for self-care, communicating needs, directing ~~care givers~~caregivers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the individual during the UCAT assessment.

(H) **"Developmental Disability"** means a severe, chronic disability of an individual that:

(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(ii) is manifested before the individual attains age 22;

(iii) is likely to continue indefinitely;

(iv) results in substantial functional limitations in three or more of the following areas of major life activity:

(I) self-care;

(II) receptive and expressive language;

(III) learning;

(IV) mobility;

(V) self-direction;

(VI) capacity for independent living; and

(VII) economic self-sufficiency; and

(v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

(I) **"Environment high risk"** means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(J) **"Environment low risk"** means member's UCAT Environment score is 5 which indicates in the UCAT assessor's clinical judgment that, although aspects of the physical environment may need minor repair/improvement, the physical environment poses little risk to member's health and/or safety.

(K) **"Environment moderate risk"** means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

(L) **"Health Assessment high risk"** means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and ~~requiring~~requires a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by~~,~~ or under the supervision of professional personnel and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

(M) **"Health Assessment low risk"** means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the ADvantage program or a

Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.
(N) **"Health Assessment moderate risk"** means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.
(O) **"IADL"** means the instrumental activities of daily living that reflect household chores and tasks within the community essential for sustaining health and safety such as:

(i) shopping,
(ii) cooking,
(iii) cleaning,
(iv) managing money,
(v) using a telephone,
(vi) doing laundry,
(vii) taking medication, and
(viii) accessing transportation.

(P) **"IADLs score in high risk range"** means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.
(Q)**"Intellectual Disability"** means that the individual has, as determined by a standardized testing by trained professionals, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.
(R) **"MSQ"** means the mental status questionnaire.
(S) **"MSQ score in high risk range"** means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.
(T) **"MSQ score at the high end of the moderate risk range"** means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.
(U) **"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.
(V) **"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability that results in rapid and/or advanced effects beyond those of regular chronic disease degeneration but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.
(W) **"Reauthorization"** means the official approval by the AA of an ADvantage member's Service Plan after the approval/authorization of the member's initial, or first year, Service Plan. At a minimum, reauthorization of an ADvantage member's Service Plan is required every 12 months.

(X) **"Recertification"** means the formal certification of medical and/or financial eligibility for an ADvantage member by OKDHS within ~~ELDERS and IMS~~the electronic systems upon completion of the annual review.

(Y) **"Redetermination of eligibility"** means a subsequent determination of eligibility for an ADvantage member after the initial eligibility decision. Redetermination of financial and medical eligibility for ADvantage members is required at a minimum of once every 12 months. A redetermination of Program Eligibility, although not required, may occur when a significant change in the service plan is authorized or a significant change in the living arrangement occurs.

(Z) **"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.

(2) **Minimum UCAT criteria**. The minimum UCAT criteria for NF level of care ~~criteria~~ are:

(A) Care need: The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or,

(II) MSQ score is at the high end of moderate risk range; or,

(III) IADLs score is in the high risk range; or,

(IV) Nutrition score is in the high risk range; or,

(V) Health Assessment is in the moderate risk range, and, in addition;

(B) Loss of independence: The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Member Support is moderate risk; or,

(ii) Environment is high risk; or,

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of Care need and (B) Loss of independence;

(C) Expanded criteria: The UCAT documents that:

(i) the member has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the individual will meet OAC 317:35-17-2(2)(A) criteria if untreated; and

(ii) the member previously has required Hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and

(iv) only by means of ADvantage Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services**. To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary

assistance);

(D) lack the ability to adequately and appropriately care for self or communicate needs to others;

(E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services.

317:35-17-4. Application for ADvantage services

(a) **Application procedures for ADvantage services**. If waiver slots are available, the application process ~~is initiated by the receipt of a UCAT, Part I or by an oral request~~initiates when an online application is completed for ADvantage services. A written financial application is not required for an individual who has an active Medicaid case. A financial application for ADvantage services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian, or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(2) When Medicaid application is being made, an assessment of resources must be completed. For applicants of the ADvantage waiver, those resources owned by the couple the month the application was made determines the spousal share of resources.

(3) When an application is received from an individual residing in a nursing facility, the applicant is referred to the Oklahoma Health Care Authority (OHCA) Living Choice program as the appropriate entity to assist individuals from nursing facility care.

(A) If OHCA Living Choice determines the applicant is ineligible for services due to the inability to assure health and welfare in a community setting, the individual is also ineligible for ADvantage waiver services.

(B) If OHCA Living Choice determines the applicant does not meet Living Choice eligibility criteria for reasons unrelated to health and welfare, the individual is eligible for the ADvantage waiver if medically and financially approved.

(b) **Date of application**.

(1) The date of application is:

(A) the date the applicant or someone acting in his/her behalf signs the application in the county office; or

(B) the date the application is stamped into the county office when the application is initiated outside the county office; or

(C) the date when the request for Medicaid is made orally and the financial application form is signed later. The date of the oral request is entered in "red" above the date the form is signed.

(2) An exception is when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contracted provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for Medicaid eligibility determination. The application date is the date the applicant

signed the application form for the provider.

(c) **ADvantage waiting list procedures.** ADvantage Program "available capacity" is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. Upon notification from the AA that 90% of the available capacity has been exceeded, OKDHS ~~Aging Services Division (OKDHS/ASD)~~Community Living, Aging and Protective Services notifies OKDHS county offices and contract agencies approved to complete the UCAT~~, Parts I and II~~ that, until further notice, requests for ADvantage services are not to be processed as applications~~,~~ but referred to AA to be placed on a waiting list of requests for ADvantage services. As available capacity permits, but remaining in compliance with waiver limits of maximum capacity, and until an increase in ADvantage available capacity occurs, the AA selects in chronological order (first on, first off) requests for ADvantage from the waiting list to forward to the appropriate OKDHS county office for processing the application. When the waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

317:35-17-5. ADvantage program medical eligibility determination

The Oklahoma ~~of~~ Human Services (OKDHS) area nurse or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT), and any other available medical information.

(1) When ADvantage care services are requested or the application is received, the:

(A) OKDHS nurse completes the UCAT; and

(B) Social services specialist (SSS) contacts the applicant within three (3) business days to initiate the financial eligibility application process.

(2) Categorical relationship is established for ADvantage services eligibility determination. When a member's categorical relationship to a disability is not established, the local SSS submits the same information, per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) of the Oklahoma Health Care Authority to request a medical categorical relationship eligibility determination. LOCEU decides on the categorical relationship to the disability using the Social Security Administration (SSA) definition. ~~An~~ SSS follow-up with SSA is required to ensure the disability decision agrees with the LOCEU decision.

(3) Community agencies and waiver service applicants may complete the application and forward to OKDHS.

(4) When an applicant is Medicaid eligible at the request time, an OKDHS nurse completes the UCAT assessment with the applicant within ten (10) business days of referral receipt for ADvantage services. The OKDHS nurse completes the UCAT assessment within twenty (20) business days of the date the Medicaid application is completed for new applicants.

(5) For initial level of care (LOC), the OKDHS nurse assesses the applicant through an electronic format such as phone or video conference~~,~~ using the UCAT, unless there are limiting factors which necessitate a face-to-face assessment.

(A) The OKDHS nurse determines LOC based upon the assessment outcome unless the applicant is medically ineligible. In this case, a face-to-face visit is scheduled to either validate the initial electronic format assessment or to provide additional documentation to support the applicant meeting medical LOC.

(B) Applicants are not medically denied access to the waiver solely based on an assessment completed through an electronic format.

(6) During the UCAT assessment, the OKDHS nurse informs the applicant of medical eligibility criteria and provides information about the different long-term care service options. The OKDHS nurse documents whether the applicant chooses nursing facility program services or ADvantage program services and makes ~~an~~ LOC and service program recommendation.
(7) The OKDHS nurse informs the applicant and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the applicant's primary and secondary informed provider choice, ensuring adherence to conflict free case management requirements.

(A) ADvantage providers, or those who have an interest in or are employed by an ADvantage provider, do not provide case management or develop the person-centered service plan. The only exception is when the ADvantage Administration demonstrates there are no more than two (2) willing and qualified entities to provide case management and develop person-centered service plans in a geographic area, and those agencies also provide other ADvantage services.

(B) When the applicant or family declines to make a provider choice, the OKDHS nurse documents the decision on the consents and rights document.

(C) OKDHS uses a rotating system to select agencies for the applicant from a list of all local, certified case management and in-home care providers, ensuring adherence to conflict free case management requirements.

(8) The OKDHS nurse documents chosen agency names, or the choice to decline to select agencies, and the applicant's agreement to receive waiver services.
(9) When the applicant's needs require an immediate interdisciplinary team (IDT) meeting with the case manager and home care provider agency nurse participation to develop a person-centered service plan, the OKDHS nurse documents the priority processing need.
(10) The OKDHS nurse forwards the completed UCAT to the area nurse or nurse designee for medical eligibility determination.
(11) When the OKDHS nurse determines the UCAT assessment indicates the member health and safety are at risk, OKDHS Adult Protective Services staff is notified immediately, and the referral is documented on the UCAT.
(12) Within ten (10) business days of receipt of a complete ADvantage application, the area nurse or nurse designee determines medical eligibility using nursing facility LOC criteria and service eligibility criteria, per OAC 317:35-17-2 and 317:35-17-3~~,~~ and enters the medical decision on the system.
(13) Upon SSS financial eligibility notification and medical eligibility approval for ADvantage entry from the area nurse or nurse designee, AA communicates with the case management provider to begin care and service plan development. AA provides the member's demographic and assessment information, and the number of case management and home care nurse evaluation units authorized for service plan development. When the member requires an immediate home visit to develop a person-centered plan, AA contacts the case management provider directly to confirm availability and request IDT priority.
(14) When a member is being discharged from a ~~nursing facility or~~ hospital and transferred home, services are in place to ensure the member's health and safety. The member's chosen case manager follows the ADvantage institutional transition case management procedures for care, and service plan development and implementation.
(15) A new medical LOC determination is required when a member requests any change in service setting, from:

(A) State Plan Personal Care (SPPC) services to ADvantage services;
(B) ADvantage to SPPC services;
(C) Nursing facility to ADvantage services; or
(D) ADvantage to nursing facility services.

(16) A new medical LOC determination is not required when a member requests ADvantage services re-activation after staying ninety (90) calendar days or less in a nursing facility when the member had previous ADvantage services and the ADvantage certification period has not expired by the date the member is discharged. Individuals residing in a nursing facility may be referred to OHCA Living Choice for assistance in transitioning to the community, as needed.

(17) When a UCAT assessment is completed more than ninety (90) calendar days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

317:35-17-14. Case management services

(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.

(1) Within one-business (1-business) day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case ~~management supervisor~~processor assigns a case manager to the member. The case manager makes a home visit to review the ADvantage program~~;~~, including its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and ~~the~~ Oklahoma ~~Department of~~ Human Services (~~DHS~~ OKDHS). The case manager will review and~~/or~~, when needed, update the Uniform Comprehensive Assessment Tool (UCAT) ~~Part III~~ and discuss service needs and ADvantage service providers. The case manager notifies the member's primary physician, identified in the UCAT ~~Part I~~, in writing that the member was determined eligible to receive ADvantage services. The notification is a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT ~~Part III~~.

(2) Within ~~fourteen-calendar (14-calendar)~~10 business days of the receipt of an ADvantage referral, the case manager completes and submits a person-centered service plan for the member, signed by the member and the case manager, to the case manager supervisor for approval and submission to the AA. The case manager completes and submits the annual reassessment person-centered service plan documents at least thirty (30) days before, but no sooner than sixty ~~B~~calendarcalendar days (60-calendar) days before the existing service plan end-date ~~but sufficiently in advance of the end-date to be received by the AA at least thirty (30) days before the end-date of the existing person-centered service plan~~. The case manager submits revisions for denied services to be resubmitted for approval within ~~five-business (5-business)~~seven-business (7-business) days to the AA. Within ~~fourteen-calendar (14-calendar)~~ten-business (10-business) days of ~~receipt of a Service Plan Review (SPR)~~notification of service conditions for short-term authorizations from the AA, the case manager submits ~~corrected person-centered service plan documentation~~the correction. Within ~~five-business (5-business)~~seven-business (7-business) days of assessed need, the case manager completes and submits a service plan ~~addendum~~change to the AA to amend current services ~~on the person-centered service plan~~. The person-centered service plan is based on the member's service needs identified by the UCAT ~~Part III~~, and includes only those ~~ADvantage~~ services required to sustain ~~and/or~~or promote the health and safety of the member. The case manager uses an

interdisciplinary team (IDT) planning approach for person-centered service plan development. ~~Except for extraordinary circumstances, the~~ IDT meetings are held in the member's home~~. When home care is the primary service, the IDT~~ and includes~~,~~ at ~~a~~ minimum, the member~~, a nurse from the ADvantage home care or assisted living provider chosen by the member, and the case manager. Otherwise, the member~~ and ~~case manager constitute a minimum IDT~~ member's legal representative if applicable, case manager, and homecare Registered Nurse.

(3) The case manager identifies long-term goals, strengths and challenges for meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ~~ADvantage~~ case manager documents ~~on the person-centered service plan~~in the electronic case file the presence of two (2) or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. ~~The case manager documents on the Electronic Visit Verification (EVV) system in the member record any instance in which a member's health or safety would be at risk when even one (1) personal care visit is missed.~~ The case manager identifies services, service provider, funding source units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates ~~review/agreement~~review and agreement with the person-centered service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative signs the person-centered service plan in the presence of the case manager. The signatures of two (2) witnesses are required when the member signs with a mark. When the member refuses to cooperate in development of the person-centered service plan or when the member refuses to sign the person-centered service plan, the case management agency refers the case to the AA for resolution. Based on the UCAT ~~Part III~~ and/or case progress notes that document chronic uncooperative or disruptive behaviors, the ~~DHS~~OKDHS nurse or AA may identify members that require AA intervention through referral to the AA's Escalated Issues unit.

(A) For members that are uncooperative or disruptive, the case manager supports the member to develop an individualized person-centered service plan to overcome challenges to receiving services. This plan focuses on behaviors, both favorable and those that jeopardize the member's well-being and includes a design approach of incremental plans and addenda that allows the member to achieve stepwise successes in behavior modification.

(B) The AA may implement a person-centered service plan without the member's signature ~~when the presence of a document that requires their signature may itself trigger a conflict. In these circumstances,~~ when mental health/behavioral issues ~~may~~ prevent the member from controlling his or her behavior to act in his or her own interest. When the member, by virtue of level of care and the IDT assessment, needs ADvantage services to ensure his or her health and safety, the AA may authorize the person-centered service plan when the case manager demonstrates effort to work with and obtain the member's agreement. Should negotiations not result in agreement with the person-centered service plan, the member may withdraw his or her request for services or request a fair hearing.

(4) Consumer-Directed Personal Assistance Services and Supports (~~CD-PASS~~CDPASS) planning and supports coordination.

(A) ~~CD-PASS~~CDPASS offers ADvantage members personal choice and control over the delivery of their in-home support service, including who provides the services and how services are provided. Members or their legal representatives have singular "employer authority" in decision-making and are responsible to recruit, hire, train, supervise and when

necessary, terminate the individuals who furnish their services. They also have "budget authority" to determine how expenditures of their expense accounts are managed.

(B) Members who elect the ~~CD-PASS~~CDPASS service option receive support from Consumer-Directed Agent/Case Manager (~~CDA/CM~~CDPASS CM) in directing their services. The ~~CDA/CM~~CDPASS CM liaison between the member and the program assists members, identifying potential requirements and supports as they direct their services and supports. ADvantage case management providers deliver required support and assign the CD-PASS members a case manager trained on the ADvantage ~~CD-PASS~~CDPASS service option, independent living philosophy, person centered service planning, the role of the member as employer of record, the individual budgeting process and service plan development guidelines. A case manager, who has completed specialized ~~CD-PASS~~CDPASS training, is referred to as a ~~CDA/CM~~CDPASS CM with respect to the service planning and support role when working with ~~CD-PASS~~CDPASS members. The ~~CDA/CM~~CDPASS CM educates the member about his or her rights and responsibilities as well as community resources, service choices and options available to the member to meet ~~CD-PASS~~CDPASS service goals and objectives.

(C) The ADvantage case management provider is responsible for ensuring that case managers serving members who elect to receive or are receiving the ~~CD-PASS~~CDPASS service option have successfully completed ~~CD-PASS~~CDPASS certification training in its entirety and have a valid ~~CDA/CM~~CDPASS CM certification issued by the AA.

(D) Consumer-directed, SoonerCare (Medicaid)-funded programs are regulated by federal laws and regulations setting forth various legal requirements with which states must comply. The ADvantage case management provider is responsible for ensuring that ~~CDA/CMs~~CDPASS CMs in their employment provide services to ~~CD-PASS~~CDPASS members consistent with certification guidelines ~~so as to be in keeping with~~following federal, state, and Waiver requirements. Non-adherence may result in remediation for the case management provider, the case manager, or both, up to and including decertification.

(E) Members may designate a family member or friend as an authorized representative to assist in the service planning process and in executing member employer responsibilities. When the member chooses to designate an authorized representative, the designation and agreement, identifying the willing adult to assume this role and responsibility, is documented with dated signatures of the member, the designee, and the member's case manager, or AA staff.

(i) A person having guardianship or power of attorney or other court-sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated authorized representative.

(ii) An individual hired to provide ~~CD-PASS~~CDPASS services to a member may not be designated the authorized representative for the member.

(iii) The case manager reviews the designation of authorized representative, power of attorney, and legal guardian status on an annual basis and includes this in the reassessment packet to AA.

(F) The ~~CDA/CM~~CDPASS CM provides support to the member in the person-centered ~~CD-PASS~~CDPASS planning process. Principles of person-centered planning are listed in (i) through (v) of the subparagraph.

(i) The ~~person~~member is the center of all planning activities.

(ii) The member and his or her representative, or support team are given the requisite information to assume a controlling role in the development, implementation, and management of the member's services.

(iii) The ~~individual~~member and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The ~~individual~~member directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals, and support needs.

(v) Person-centered planning results in personally-defined outcomes.

(G) The ~~CDA/CM~~CDPASS CM encourages and supports the member, or as applicable his or her designated authorized representative, to lead, to the extent feasible, the ~~CD-PASS~~CDPASS service planning process for personal services assistance. The ~~CDA/CM~~CDPASS CM helps the member define support needs, service goals, and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences, the ~~CDA/CM~~CDPASS CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the ~~CDA/CM~~CDPASS CM assists the member to translate the assessment of member needs and preferences into an individually tailored, person-centered service plan.

(H) To the extent the member prefers, the ~~CDA/CM~~CDPASS CM develops assistance to meet member needs using a combination of traditional personal care and ~~CD-PASS PSA~~CDPASS Personal Service Assistant (PSA) services. However, the ~~CD-PASS~~CDPASS IBA and the PSA unit authorization is reduced ~~proportional~~proportionally to agency personal care service utilization.

(I) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the ~~CDA/CM~~CDPASS CM to finalize the person-centered service plan. The start date must be after:

(i) authorization of services;

(ii) completion and approval of the background checks; and

(iii) completion of the member employee packets.

(J) Based on outcomes of the planning process, the ~~CDA/CM~~CDPASS CM prepares an ADvantage person-centered service plan or plan amendment to authorize ~~CD-PASS~~CDPASS personal service assistance units consistent with this individual plan and notifies existing duplicative personal care service providers of the end-date for those services.

(K) When the plan requires an Advanced Personal Service Assistant (APSA) to provide assistance with health maintenance activities, the ~~CDA/CM~~CDPASS CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific health maintenance tasks safely and competently, when the~~:~~

~~(i)~~ member's APSA was providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the APSA, additional documentation of competence is not required~~; and~~

~~(ii) member and APSA attest that the APSA was performing the specific health maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two (2) months in the period immediately prior to~~

~~being hired as the PSA, and no evidence contra indicates the attestation of safe and competent performance by the APSA, additional documentation is not required~~.

(L) The ~~CDA/CM~~CDPASS CM monitors the member's well-being and the quality of supports and services and assists the member in revising the PSA services plan as needed. When the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the ~~CDA/CM CD-PASS~~CDPASS CM, based upon an updated assessment, amends the person-centered service plan to modify ~~CD-PASS~~CDPASS service units ~~appropriate~~appropriately to meet the additional need and submits the plan amendment to the AA for authorization and update of the member's IBA.

(M) In the event of a disagreement between the member and ~~CD-PASS~~CDPASS provider the following process is followed:

(i) either party may contact via ~~a toll free~~the toll-free number ~~the Member/Provider Relations Resource Center~~ to obtain assistance with issue resolution;

(ii) ~~when the issue cannot be resolved with assistance from the Member/Provider Relations Resource Center or from CD-PASS Program Management, the CD-PASS Program Management submits the dispute to the ADvantage Escalated Issues Unit for resolution. The Escalated Issues Unit works with the member and provider to reach a mutually-agreed upon resolution;~~

~~(iii)~~ when the dispute cannot be resolved by ~~the ADvantage Escalated Issues Unit~~AA protocol, it is heard by the Ethics of Care Committee. The Ethics of Care Committee makes a final determination ~~with regard to settlement of the~~regarding dispute settlement; or

~~(iv)~~(iii) at any step of this dispute resolution process the member may request a fair hearing to appeal the dispute resolution decision.

(N) The ~~CDA/CM~~CDPASS CM and the member prepare an emergency backup response capability for ~~CD-PASS~~CDPASS PSA/APSA services in the event a PSA/APSA services provider essential to the individual's health and welfare fails to deliver services. As part of the backup planning process, the ~~CDA/CM~~CDPASS CM and member define what failure of service or neglect of service tasks constitutes a risk to health and welfare to trigger implementation of the emergency backup when (i) or (ii) may be used. Identification of:

(i) a qualified substitute provider of PSA/APSA services and preparation for their quick response to provide backup emergency services, including execution of all qualifying background checks, training, and employment processes; and/or

(ii) one (1) or more qualified substitute ADvantage agency service providers, adult day health, personal care, or nursing facility (NF) respite provider, and preparation for quick response to provide backup emergency services.

(O) To obtain authorizations for providers other than PSA and APSA identified as emergency backups, the CDPASS CM requests the AA authorize and facilitate member access to adult day health, agency personal care, or NF respite services.

(5) The CDPASS case manager submits the person-centered service plan to the CDPASS case management supervisor for review. The CDPASS case management supervisor conducts the review/approval of the plans ~~within two business (2 business) days of receipt~~ from the CDPASS case manager or returns the plans to the CDPASS case manager with notations of errors, problems, and concerns to be addressed. The CDPASS case manager re-submits the corrected person-centered service plan to the CDPASS case management supervisor ~~within two-~~

~~business (2-business) days~~. The CDPASS case management supervisor returns the approved person-centered service plan to the CDPASS case manager. Within one-business (1-business) day of receiving supervisory approval, the case manager submits, the person-centered service plan to the AA. Only priority service needs and supporting documentation may be submitted to the AA as a "Priority" case with justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the NF. Corrections to service conditions set by the AA are not considered a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a NF.

(6) Within one-business (1-business) day of notification of care plan and person-centered service plan authorization, the CDPASS case manager communicates with the service plan providers and member to facilitate service plan implementation. Within ~~five-business (5-business)~~seven-business (7-business) days of notification of an initial person-centered service plan or a new reassessment service plan authorization, the CDPASS case manager visits the member, gives the member a copy of the person-centered service plan and evaluates the service plan implementation progress. The CDPASS case manager evaluates service plan implementation on the following minimum schedule:

(A) within thirty-calendar (30-calendar) days of the authorized effective date of the person-centered service plan or service plan ~~addendum~~amendment; and

(B) monthly after the initial thirty-calendar (30-calendar) days follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans**. The AA authorizes the individual person-centered service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, service plan cost effectiveness for service providers that are ADvantage authorized and SoonerCare contracted, and that the delivery of ADvantage services are consistent with the member's level of care need, the service plan is authorized.

(1) Except as provided by the process per Oklahoma Administrative Code (OAC) 317:30-5-761~~(6)~~, family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member, such as the spouse or ~~parent of a minor child~~or legal guardian.

(2) ~~DHS-AS may, per OAC 317:35-15-13, authorize personal care service provision by an Individual PCA, an individual contracted directly with OHCA. Legally responsible family members are not eligible to serve as Individual PCAs.~~

~~(3)~~ When a complete service plan authorization or amendment request is received and the service plan is within cost-effectiveness guidelines, the AA authorizes or denies authorization within ~~five-business (5-business)~~seven-business (7-business) days of receipt of the request. When the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the member to access services in an alternate setting or program. When the request packet is incomplete, the AA notifies the case manager immediately and puts a hold on authorization until the requirements are received from case management.

~~(4)~~(3) The AA authorizes the service plan by entering the authorization date. Notice of authorization of the service plan is available through the appropriate designated software or web-based solution. AA authorization determinations are provided to case management within one-business (1-business) day of the authorization date. A person-centered service plan may be

authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval within ~~five-business (5-business)~~seven-business (7-business) days.

~~(5)~~(4) For audit purposes including Program Integrity reviews, the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. Federal or State quality review and audit officials may obtain a copy of specific person-centered service plans with original signatures by submitting a request to the member's case manager.

(c) **Change in service plan**. The process for initiating a change in the person-centered service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the member's person-centered service plan. The requested changes and justification are documented by the service provider and, when initiated by a direct care provider, are submitted to the member's case manager. When in agreement, the case manager submits the service changes within ~~five-business (5-business)~~seven-business (7-business) days of the assessed need. The AA authorizes or denies the person-centered service plan changes, per OAC 317:35-17-14.

(2) The member initiates the process for replacing personal care services with ~~CD-PASS in geographic areas where CD-PASS~~CDPASS services ~~are available~~. The member may contact the AA ~~or call the toll-free number~~ to process requests for ~~CD-PASS~~CDPASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour (4-hour) or more adjustment in services per week, requires an updated UCAT ~~Part III~~ reassessment by the case manager. The case manager develops and submits an amended or new person-centered service plan, as appropriate, ~~and submits the new amended person-centered service plan~~ for authorization.

(4) One (1) or more of the following changes or service requests require an Interdisciplinary Team review and service plan goals amendment:

(A) the presence of two (2) or more ADvantage members residing in the same household; or

(B) the member and personal care provider residing together; or

(C) a request for a family member or legal representative to be a paid ADvantage service provider~~; or~~

~~(D) a request for an individual PCA service provider~~.

(5) Based on the reassessment and consultation with the AA as needed, the member may, as appropriate, be authorized for a new person-centered service plan or be eligible for a different service program. When the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated signature indicating voluntary withdrawal for ADvantage program services. When unable to obtain the member's consent for voluntary closure, the case manager requests AA assistance. The AA requests that the ~~DHS area~~OKDHS nurse initiate a reconsideration of level of care.

(6) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates the only willing and qualified entity to provide case management and develop person-centered service plans in a geographic area also provides HCBS.

317:35-17-18. ADvantage services during hospitalization or NF placement

When the member's ~~DHS~~OKDHS social worker, ADvantage case manager, or the ~~AA~~ADvantage Administration (AA) is informed by the member, family, or service provider of a member's hospitalization or placement in a nursing facility (NF), that party determines the date of the member's institutionalization and communicates the date, name of the institution, reason for placement, and expected duration for placement to the other ADvantage Program Administrative partners. When a member requires hospital or NF services, the case manager assists the member to access institutional care, periodically monitors the member's progress during the institutional stay, and, as appropriate, updates the person-centered service plan and prepares services to start on the date the member is discharged from the institution and returns home. All case management units for institution transition services to plan for and coordinate service delivery and to assist the member to safely return home, even when provided while the person is in an institution, are considered delivered on and billed for the date the member returns home from institutional care.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and the ~~ADvantage Administration (AA),~~AA and coordinates the resumption of services.

(2) **Nursing Facility placement of less than 30-calendar days.** When the member returns home from a NF stay of 30-calendar days or less or when notified of the member's anticipated discharge date, the case manager notifies relevant providers, the member's ~~DHS~~OKDHS worker and the AA of the discharge and coordinates the resumption of ADvantage services in the home.

(3) **Nursing Facility placement longer than 30-calendar days.** When the member is scheduled to be discharged and return home from a NF stay that is longer than 30-calendar days, the member's ~~DHS~~OKDHS worker, ADvantage case manager, or the AA, whoever first receives notification of the discharge, notifies other ADvantage Program Administrative partners to expedite the restart of ADvantage services for the member. The member's case manager provides institution transition case management services to assist the member to re-establish ~~him~~himself or herself safely in the home. Individuals residing in a NF may be referred to OHCA Living Choice for assistance transitioning to the community, as needed.

317:35-17-19. Closure or termination of ADvantage services

(a) **Voluntary closure of ADvantage services**. When the member requests a lower level of care than ADvantage services~~,~~ or agrees that ADvantage services are no longer needed to meet his or her needs, a medical level of care decision by the area nurse or nurse designee~~,~~ is not needed. The closure request is completed and signed by the member and the ADvantage case manager and sent to the ADvantage Administration (AA) ~~to be placed in the member's case record~~for processing in the electronic system. ~~The AA notifies the Oklahoma Department of Human Services (DHS) area nurse or area nurse designee of the voluntary closure and effective date of closure.~~ When the member's written request for closure cannot be secured, ~~the ADvantage case manager documents in the member's case record~~ the reasons for the voluntary termination of services and alternatives for services are documented in the electronic system.

(b) **Closure due to financial or medical ineligibility**. The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility**. When the local ~~DHS~~Oklahoma Human Services (OKDHS) office determines a member does not meet financial eligibility criteria, the DHS office notifies the area nurse or area nurse designee who closes the member's authorization and notifies the member

and AA of financial ineligibility by system-generated mail. The AA notifies the member's providers of the decision. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** When the ~~DHS~~OKDHS office is notified by the area nurse or ~~area nurse~~ designee of a decision that the member is no longer medically eligible for ADvantage services, the ~~DHS~~OKDHS office notifies the member and AA of the decision. Refer to Oklahoma Administrative Code (OAC) 317:35-17-16 (d). The AA notifies the member's providers of the decision.

(c) **Closure due to other reasons**. Refer to OAC 317:35-17-3(e) - (h).

~~(d) **Resumption of ADvantage services.** When a member approved for ADvantage services is without services for less than ninety (90) calendar days and has a current medical and financial eligibility determination, services may be resumed using the previous authorized person-centered service plan. When a member requests to have his or her services restarted after ninety (90) calendar days, the member must request a new referral for services through the DHS county office or AA. When a member is determined eligible for ADvantage services and transistions from a hospital or a nursing facility to a community setting, an ADvantage case manager may provide Institution Transition case management services to assist the member to establish or re-establish him or herself safely in the home.~~

317:35-17-21.1. ADvantage ~~and agency Personal Care~~ provider certification

ADvantage Administration (AA) ~~forwards~~provides real-time information on all certified ADvantage ~~and Personal Care agency~~ providers providing services in ~~the~~ specific OKDHS ~~area~~counties ~~to the area nurse and OKDHS county director~~through the Certified Agencies Report (CAR) located in the electronic database. The provider information includes agency name, address, contact person ~~for ADvantage/Personal Care programs~~, provider number, a list of ~~ADvantage/Personal Care~~ADvantage services the provider is certified to deliver, and other information as needed by OKDHS staff to achieve efficient service delivery. The AA certifies ADvantage case managers and case management supervisors. The AA maintains a master registry of certified ADvantage case management supervisors and case managers. Case manager certifications are based on successful completion of ADvantage case management training and demonstration of competency in case management and, for supervisors, case management supervision. ~~As~~The CAR is updated as additional providers are certified in an OKDHS ~~area~~county or if a provider loses certification~~, AA provides appropriate notice to the area nurse and OKDHS county director in counties affected by the certification changes~~. The ~~OHCA~~Oklahoma Health Care Authority (OHCA) may execute agreements to provide care only with qualified individuals and agencies and facilities which are properly licensed or certified by the state licensing or certification agency and, as applicable, Title XIX certified. The agreement is initiated by application from the individual agency or facility. The agreement expires on a specified date, with termination of the agency license or certification, or automatically terminated on notice, with appropriate documentation, to OHCA that the individual agency or facility is not in compliance with Title XIX (or other federal long-term care) requirements. The AA certifies Title XIX providers of ADvantage services with the exception of pharmacy and medical equipment and supply providers.

317:35-17-26. Ethics of Care Committee

(a) The ADvantage Program Ethics of Care Committee (EOCC) reviews ~~members~~members' cases when the ADvantage, State Plan Personal Care programs or a provider contracted to provide these services determines that a member's identified needs cannot be met through the provision of the ADvantage program or State Plan Personal Care program and other formal or informal services are not in place or immediately available to meet the members health and safety needs. The EOCC is a core group of designated representatives from Oklahoma ~~Department of~~ Human Services (~~DHS~~OKDHS) Community Living, Aging and Protective Services and Oklahoma Health Care Authority staff and are experts in State Medicaid programs, specifically ADvantage waiver and State Plan Personal Care, and experienced in addressing member issues ~~as it pertains~~pertaining to policy, program, and service delivery.

(b) EOCC decisions are predicated upon four (4) guiding principles.

(1) **Sustainability of member services.** The overarching concern of EOCC is to ensure ~~that~~ all efforts are made to sustain the member's services when possible. EOCC explores options and renders a decision that maintains member safety while averting the primary issue of concern before the EOCC. This is done while assuring member health and safety as outlined in Oklahoma Administrative Code (OAC) 317:35-17-3~~(h) (1-7)~~.

(2) **Cultural competence.** EOCC considers the contextual details of the situation to promote needs and interests of ADvantage members and emphasizes understanding of the members culture and relevant circumstances.

(3) **Balance and reciprocity.** This assures member health and safety is reliant upon the member's cooperation and that of the member's community network, or informal supports. EOCC evaluates the viability of the member's resources to sustain health and safety independent of Medicaid paid supports when making decisions.

(4) **Education and mitigation.** EOCC uses decision-making processes for determining program appropriateness for cases that are problematic or controversial with respect to being able to meet member needs within program constraints. The decision-making process engages expertise from any area of program function relevant to the case in question, when necessary. When the case submitted for review is deemed invalid or lacking sufficient merit for review, EOCC rescinds the review until the case meets the appropriate criteria for review.

(c) EOCC reviews ADvantage and State Plan Personal Care cases, including but not limited to, when:

(1) the member can no longer safely remain in the community;

(2) the member shows a consistent pattern of non-compliance and non-cooperativeness that prevents delivery of the authorized person-centered service plan or care plan;

(3) the provider's and/or ~~DHS~~OKDHS staff's safety cannot be assured due to the actions of the member, ~~visit~~visitor, or another household member;

(4) the services required to meet member needs are beyond the scope of defined waiver or State Plan Personal Care services;

(5) the new ADvantage or State Plan Personal Care members meet financial and medical eligibility for the program, but require review for program appropriateness or community potential;

(6) the previous dis-enrolled ADvantage or State Plan Personal Care members ~~that~~ request re-enrollment into the ADvantage or State Plan Personal Care programs;

(7) the member scheduled for an administrative hearing in which the hearing officer requests EOCC review and input;

(8) members are under investigation or review by a federal authority; or

(9) all cases in which administrative review and input are warranted.

(d) ADvantage Consumer Directed Personal Assistance Service and Supports (~~CD-PASS~~CDPASS) service option cases are reviewed ~~for~~when the:

(1) circumstances under review are not addressed by ~~CD-PASS~~CDPASS requirements for member eligibility;

(2) ~~a~~ case scenario is not otherwise covered by an established process;

(3) established processes of the ~~CD-PASS~~CDPASS program do not allow for an adequate resolution to the issues; or

(4) ~~CD-PASS~~CDPASS eligibility impacts ADvantage eligibility, such as:

(A) eligibility is removed but that action may place the member at a greater risk; or

(B) a member ~~and/or~~or their legal agent are removed from ~~CD-PASS~~CDPASS services due to allegations of fraudulent or illegal actions that may result in the member's loss of ADvantage eligibility.

(e) EOCC review processes include~~:~~ (1) through (11).

(1) The ~~ADvantage Administration (AA)~~AA Member Relations Program Assistant Administrator ~~for Member/Provider Relations department~~ chairs the EOCC. He or she is responsible to appoint qualified representatives to the EOCC ~~committee~~;

(2) ~~committee~~Committee members, case representatives, ~~or~~and presenters are required to adhere to Health Insurance Portability and Accountability Act and ~~DHS~~OKDHS confidentiality standards and be discreet when reviewing and discussing cases under consideration of all records and information disclosed in carrying out the duties and activities of the committee;

(3) ~~all~~All cases ~~that meet~~meeting the defined criteria for EOCC review are submitted to AA ~~Member/Provider~~Member Relations or Escalated Issues teams for processing and presentation;

(4) ~~the~~The Escalated Issues team formally requests a meeting for EOCC case review and ~~develop~~develops a meeting agenda and ~~provide~~provides EOCC members with relevant supporting documentation ~~of~~for EOCC review prior to the scheduled meeting;

(5) ~~a~~A quorum (half plus one committee member) is present to make a decision or recommendation on any case presented to the EOCC;

(6) ~~designees~~Designees are not substituted for EOCC members;

(7) ~~the~~The EOCC Chair is notified in advance when it becomes necessary for other parties to be invited due to their expertise on the subject matter;

(8) ~~case~~Case presenters are dismissed after their presentations are complete, and the EOCC proceeds to mitigate the case;

(9) ~~upon~~Upon completion of the committee discussion, the EOCC Chair calls for a vote. A majority vote carries the motion. When a tie ensues, the Escalated Issues team Program Manager casts the deciding vote;

(10) ~~a~~A member determined by EOCC to be ineligible for ADvantage or ~~Medicaid~~ State Plan Personal Care program services is notified in writing by ~~DHS~~OKDHS of the determination and of his or her right to appeal the decision; and

(11) EOCC maintains all meeting minutes, decisions, court hearings, and files generated by our Escalated Issues department pertaining to the member indefinitely.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-2. Nursing Facility (NF) program medical eligibility determination

The Oklahoma ~~Department of~~ Human Services ~~(DHS)~~(OKDHS) area nurse or nurse designee,

determines medical eligibility for NF services based on the ~~DHS~~OKDHS nurse's Uniform Comprehensive Assessment Tool (UCAT) ~~Part III~~ assessment of the client's needed level of care, the outcome of the Level II Preadmission Screening and Resident Review (PASRR), when completed, and his or her professional judgment. The Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) makes some determinations when the PASRR is involved. Refer to Oklahoma Administrative Code (OAC) 317:35-19-7.1(3) for NF level of care medical eligibility requirements.

(1) When NF care services are requested prior to admission, the same rules related to medical eligibility determination identified in OAC 317:35-17-5 for ADvantage services are followed.

(2) The ~~DHS~~OKDHS nurse reviews the PASRR Level I in the OHCA system; completes the UCAT ~~III~~; and enters the date OHCA received the PASRR Level I (LTC-300R) from the NF and admission date to the NF; medical eligibility effective date and notes any Level II PASRR results if available in the UCAT ~~Part III~~. This information is submitted to the ~~DHS~~OKDHS area nurse for medical eligibility determination.

(3) PASRR requirements are identified in OAC 317:35-19-8 and 317:35-19-9.

(4) When it is not possible ~~for~~to complete the UCAT Part ~~III~~ assessment ~~to be completed~~ prior to admission, the NF is responsible for notifying ~~the DHS~~OKDHS of the admission. Notification is mailed or faxed on ~~DHS~~OKDHS Form 08MA083E, Notification Regarding Patient In A Nursing Facility, Intermediate Care Facility for the Intellectually Disabled or Hospice, and Management Recipient Funds to the local ~~DHS~~OKDHS county office. Upon receipt, the ~~DHS~~OKDHS county office processes Forms 08MA083E and 08MA084E and completes and forwards the Form 08MA038E, Notice Regarding Financial Eligibility to the NF. Identified sections of the UCAT ~~Part III~~ reflecting the domains for meeting medical criteria are completed for applicants residing in the NF at the time of assessment. The area nurse or nurse designee, confirms the date of medical eligibility and records it in the system. The facility is responsible for performing the PASRR Level I screen and consulting with OHCA staff to determine when a need exists for a Level II screen. The ~~DHS~~OKDHS nurse completes the assessment within fifteen-business (15-business) days of PASRR clearance when the individual's needs are included in an active ~~DHS~~OKDHS coded case. When the individual's needs are not included in an active case, the assessment is completed within twenty-business (20-business) days of PASRR clearance.

(5) The area nurse or nurse designee, evaluates the PASRR Level I screen and the UCAT ~~Part III~~ in consultation with the ~~DHS~~OKDHS nurse when the completed LTC-300R and/or facility documentation shows a need exists for a possible Level II screen. The area nurse or nurse designee consults with OHCA staff as necessary.

(6) The area nurse or nurse designee, evaluates the UCAT ~~Parts I and III~~, to determine if the applicant meets the medical eligibility criteria for NF level of care. Individuals may be medically-certified for NF level of care for various lengths of time depending on the client's needs. The area nurse or nurse designee, enters the medical eligibility decision and, when required, the medical certification review date into ~~Aging Services Division Electronic Data Entry and Retrieval System (ELDERS)~~the electronic system within ten-business (10-business) days. A medical eligibility redetermination is not required when a client is discharged from the NF for a period not to exceed ninety-calendar (90-calendar) days and the original certification is current.

(7) When the ~~DHS~~OKDHS nurse recommends NF level of care and the client is determined by the area nurse or nurse designee, not to be medically eligible for NF level of care, the

~~DHS~~OKDHS nurse can submit additional information to the area nurse or nurse designee. When necessary, a visit by the ~~DHS~~OKDHS nurse to obtain additional information is initiated at the recommendation of the area nurse or nurse designee.

(8) Categorical relationship must be established for determination of eligibility for NF services. When categorical relationship to disability has not been established, the worker submits the same information, per OAC 317:35-5-4(2), to the LOCEU to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship to the disabled applicant using the Social Security Administration (SSA) definition. A follow-up with the SSA by the ~~DHS~~OKDHS worker is required to ensure the SSA disability decision agrees with the LOCEU decision.

317:35-19-18. Change in level of long-term medical care

(a) When a member is receiving Personal Care services and requests nursing facility care ~~or when a member is in a nursing facility and requests Personal Care services~~, a new Uniform Comprehensive Assessment Tool (UCAT) is required. ~~The UCAT is updated if the member is in the nursing facility and requests ADvantage waiver services. No new medical decision is needed. Also, no~~No new medical decision is needed for admission to a nursing facility from home if the period of absence from the nursing facility is less than 90 days. No new medical decision is needed if the member loses financial eligibility but maintains medical eligibility by having a current medical decision and by remaining in the facility during the period of financial ineligibility.

(b) When there is a decision that a member approved for one level of long-term care is eligible for a different level of care, the local office is advised by update of the file. ~~If the change is from facility care to Personal Care, a new UCAT, Part III care plan, service plan, and other required forms are submitted to the area nurse, or nurse designee. If the Personal Care member requests a decision regarding facility care prior to admission to a facility, the LTC nurse is responsible for submitting the UCAT, Part III, and Form LTC-300R to the area nurse, or nurse designee for a decision.~~

(c) When the area nurse~~, or nurse designee,~~ determines that a new nursing ~~care~~facility member ~~no longer needs~~does not meet this level of care, payment may be continued while the member, or other responsible person, makes other arrangements. The length of such continuation of payment depends upon the circumstances~~,~~ but must allow time for the appropriate advance notice to the member and cannot exceed 60 days from the date of the decision.