MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
March 7, 2012
1:00 p.m. – Ponca Conference Room
2401 NW 23rd St., Suite 1A
Oklahoma City, OK 73107

I. Welcome, Roll Call, and Public Comment Instructions

II. Approval of minutes of the January 19, 2012 Medical Advisory Committee Meeting

III. MAC Member Comments/Discussion

IV. Legislative Update: Nico Gomez, Deputy Chief Executive Officer

V. Financial Report: Gloria Hudson, Director of General Accounting
   A. December Financial Summary
   B. December Financial Detail Report
   C. Supplemental Hospital Offset Provider Payment (SHOPP)

VI. SoonerCare Operations Update:
   A. SoonerCare Programs Report – Shelly Patterson, Marlene Asmussen and Rebekah Gossett - Child Health, Care Management and MAU
   B. Hardware Cutover – Jerry Scherer, Director of Information Services
   C. Durable Medical Equipment – Stan Ruffner, DME Program Director

VII. Action Items: Melinda Jones, Waiver Administration and Development Director

OHCA Initiated

11-21 Living Choice Re-enrollment

OHCA rules for the Living Choice demonstration program are revised to clarify that individuals residing in a nursing facility or ICF/MR in lieu of incarceration are not eligible for the Living Choice program. Rules are also revised to add that Living Choice members who have completed their full 365 days of eligibility and are re-institutionalized for 90 consecutive days are eligible to re-apply for an additional 365 days of service.

Budget Impact – Federal $112,908; State $14,866

OKDHS Initiated

11-39 ADvantage Waiver Annual Clean-up Revisions

OHCA rules for the ADvantage Waiver are revised to remove language requiring transportation services to be provided by Adult Day Health Centers, provide clarification of family support services versus waiver services, add language clarifying "client support moderate risk", "client support high risk" and addition of language describing "client support low risk" and "environmental low risk". Policy is also

revised to add eligibility language clarifying member reauthorization, recertification and redetermination, clarification regarding the member's level of need in order to be eligible for waiver services, clarification about the types of living arrangements allowable for ADvantage members, and clarification regarding the member's health, safety and welfare. Additionally, policy is revised to remove language allowing a financial eligibility assessment for individuals who are not applying for waiver services, add clarification regarding when a new level of care determination is required, removal of language requiring recertification of the member by a case manager and requiring an OKDHS nurse to provide medical certification at a minimum, annually. Lastly, changes include the addition of language regarding plan of care documentation when more than one member of a household receives waiver services, clarification regarding the use of family members as paid providers, clarification of conditions requiring a member's service plan goals, the removal of policy regarding the expedited eligibility determination process (SPEED) and other minor clean-up revisions.
Budget Impact – Budget Neutral

VIII. New Business

IX. Adjourn

Next Meeting: Thursday, May 17, 2012.

MEDICAL ADVISORY COMMITTEE MEETING
Draft Meeting Minutes
January 19, 2012

Members attending: Ms. Bellah, Dr. Bourdeau, Ms. Karen Bradford for Ms. Sherry Davis, Ms. Brinkley, Dr. Crawford, Ms. Felty, Ms. Fritz, Mr. Goforth, Ms. Thayer for Mr. Howard Hendrick, Ms. Holiman-James, Mr. Jones, Ms. Annette Mays for Mr. Sczepanski, Mr.McAdoo, Dr. McNeill, Mr. Pilgrim, Dr. Post, Dr. Rhoades, Dr. Rhynes, Dr. Simon, Ms. Slatton-Hodges for Ms. White, Mr. Rick Snyder for Ms. Patti Davis, Ms. Stockton, Mr. Tallent, Dr. Wells, Dr. Woodward.

Members absent: Ms. Bates, Ms. Case, Dr. Cavallaro, Dr. Grogg, Dr. McCrory, Dr. Ogle, Dr. Wright

I. Welcome, Roll Call, and Public Comment Instructions

Dr. Crawford welcomed the committee members and called the meeting to order. Roll call established the presence of a quorum. There were requests for public comment.

Ms. Teresa Tisdell stated that a number of individuals she sees are quadriplegic, but are driving, working and living independently. She said some also have children they are raising on their own. She understands the need for cost management, but is concerned the patients will have the necessities required. Ms. Tisdell requested that the MAC listen to the individual present who currently uses closed catheter systems. She described some of the difficulties these patients have using wheelchairs, and traveling around in public places, where resources are limited. She expressed concerns that some of these patients experience costly urinary tract infections, and others may be confined to home if the policy is not properly implemented.

Mr. Willis Washington, II representing Users First Alliance addressed the MAC. He described his own spinal cord injury and pointed out that most of the people in the room did not have the visible disability that he had. He expressed alarm that OHCA had reported only 8 urinary tract infections in their data. He pointed out that the closed catheter system, although a bit more expensive, appeared to be a healthier process, and that reducing the number to 2 a day would limit his ability to be out in public. He stressed that the need for the closed systems was particularly to ensure his independence as well as his long-term health.

Mr. Wade Hammell, representing OPA, address the issue of the behavioral health rule and the CDC form. He mentioned that it was discussed at the Behavioral Health Advisory Council last week. He expressed concern that the providers in the mental health community had undergone a period in which they were not being paid on a regular basis and felt this was due to the prior authorization system problems and was related to the CDC as well. He recommended OHCA remove language regarding the CDC form and asked that the MAC reject the Emergency Rule as a whole or at least remove the specific clauses that refer to the CDC requirement and prior authorization.

Dr. Crawford thanked all speakers.

II. Approval of minutes of the November 16, 2011 Medical Advisory Committee Meeting

Dr. Rhynes approved the minutes as presented. Dr. Post seconded.
Approved.

III. MAC Member Comments/Discussion

Dr. Simon discussed the SoonerRide restriction that only 1 person can accompany the patient going to the doctor's office. He is concerned for people who need an interpreter, and mothers who (from certain cultures) will not go without their husbands, and those who are just reluctant to go by themselves. Mr. Rupe explained that our basic standard is that we will reimburse travel for only 1 attendant. However, the

SoonerRide staff do have the flexibility to consider specific needs if they are known, and arrangements are made 3 days in advance.

Dr. Keenan pointed out that if a patient is apprehensive about going without their husband, they may also be apprehensive about addressing the issue with the SoonerRide staff. It would be helpful if doctors' offices would intervene if they support the patient's request by notifying SoonerRide. The MAC was in agreement.

Discussion by Dr. Simon about medications. He asked about medications not listed in Tiers, such as Accutane. Dr. Keenan reminded the MAC that we do not have a formulary. Dr. Woodward pointed out that certain drugs are not covered, and others require prior authorization. Staff was instructed to follow up with Dr. Simon regarding Accutane.

IV. Financial Report: Gloria Hudson-Hinkle, Director of General Accounting

A. November Financial Summary
B. November Financial Detail Report

Ms. Hudson-Hinkle reviewed the handouts. There were no questions.

V. SoonerCare Operations Update: Von Lawson, Director, Opportunities for Living Life

A. SoonerCare Programs Report
B. HCBS Waivers

Mr. Lawson reviewed the handouts. There were no questions.

VI Durable Medical Equipment (DME) Recycling Program: Stanley Ruffner, DME Director

Mr. Ruffner reviewed the handout. OHCA will retrieve and donate used/gently used DME to individuals who are disabled or elderly. The program can also accept donations. Mr. Ruffner introduced Ms. Linda Jaco, Director of Sponsored Programs. She represents ABLE Tech with whom we have contracted to implement this program. A website will be up soon for providers and citizens. In the Kansas program, 85% of the donations actually come from non-Medicaid donations. Mr. Ruffner asked the MAC members to help champion the program. The pilot starts in Oklahoma County. An update will be provided to the MAC at the next meeting.

VII. Electronic Access to SoonerCare Member Health Information: Adolph Maren, Planning Project Manager

Mr. Maren reviewed the handout. Approximately 43 percent of states use the Opt Out model, making patient information available immediately. Studies show about 5% of participants opt out initially, but then of that 5%, 70% ultimately opt back in once they see the value of the program. Mr. Maren also explained MedAi, our predictive modeling tool.

Dr. Crawford asked if our current program is it an opt out. Mr. Maren answered – Right now the data is just claims. There is not specific clinical patient information, therefore, specific consent is not needed.

Dr. Post pointed out that the sensitive information is the information PCPs actually need for patient care.

VIII. Action Items: Traylor Rains, Policy Development Coordinator

<u>OHCA Initiated</u>

11-08 Date of Application Clarification - Eligibility rules are revised to provide clarification regarding dates of application for SoonerCare services. Current rules are difficult to interpret and, in some instances, obsolete. The revisions will make interpreting rules easier for OHCA staff, contracted agency partners, and applicants to understand when an application is considered received and completed. Rules are further amended to add the Notification of Date of Service feature for hospitals in official agency policy.
Budget Impact – Budget neutral.

11-13 My Life, My Choice Waiting List Clarification – OHCA rules for the My Life, My Choice Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
Budget Impact – Budget neutral.

11-14 Sooner Seniors Waiver Waiting List Clarification – OHCA rules for the Sooner Seniors Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
Budget Impact – Budget neutral.

11-29 Medically Fragile Waiver Waiting List Clarification – OHCA rules for the Medically Fragile Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
Budget Impact – Budget neutral.

Mr. Pilgrim stated that first in, first out (FIFO), which sounds at first to be the simplest and fairest approach, is probably not the most flexible way to administer the waiting list. On a waiting list of 300 people, these are patients with varying levels of need for access to the services. On DDSD waiting lists, DHS has moved individuals in state-run ICFMRs to the front of the list, probably because DDSD has mandates to reduce the size of those institutions. If you put a FIFO methodology in place without any process to change the order administratively, then you take away the agency's flexibility to deal with specific situations.

Mr. Jones responded that as the Rules presently stand, included in the approved waivers, currently we already have the opportunity through "reserve capacity" to bring in individuals based on need and to address emergency situations. We also have the authority in the waiver to address those with special access needs on an emergency basis.

11-19 End Stage Renal Disease Payment Methodology – Policy, the State Plan, and reimbursement methodology will be updated to correspond to new Medicare guidelines regarding payment to End Stage Renal Disease (ESRD) facilities. Currently policy and methodology utilizes Medicare's old composite rate for a defined set of ESRD items and services, while paying separately for services not included in the composite rate, such as drugs and laboratory tests. This payment system is replaced with a new bundled prospective payment system (PPS), in which a single bundled payment to the ESRD facility for each treatment will cover all renal dialysis services. If the change is not made, OHCA will be out of line with Medicare reimbursement rates for this provider type. **Budget Impact:** $959,000 total; $344,000 State Share.

11-25A&B SoonerRide Clarification - SoonerCare non-emergency transportation rules are revised to clarify OHCA's current policy concerning meals and lodging, travel distance, and eligibility. This rule will

assist with future cost savings and prevent abuse of services. This rule will also ensure services for current and future SoonerCare members.
Budget Impact – Budget neutral.

11-26 Revocation of Enrollment and Billing Privileges - OHCA's provider agreements policy is expanded to explain situations in which a provider agreement and billing privileges may be revoked for improper actions. These situations include noncompliance with enrollment requirements, provider misconduct, and felony convictions, among others. These rules will assist the agency in provider integrity determinations and will align agency policy with CMS's Medicare regulations on provider agreements.
Budget Impact – Budget neutral.

11-27 Outpatient Behavioral Health Rules - Agency Behavioral Health rules are revised in order to sufficiently and accurately set forth the substantive requirements for providing covered SoonerCare behavioral health services. Provider credentials and coverage guidelines will be transferred from the current Behavioral Health Provider Manual to the Agency's Behavioral Health rules in order to comply with rule promulgation requirements set forth in Oklahoma Administrative Procedures Act (APA). These revisions will not only ensure that the Agency remains in compliance with the APA, but also provides the Agency the necessary legal basis to successfully maintain program integrity. Additionally, Outpatient Behavioral Health, Psychologist and Licensed Behavioral Health Professional (LBHP) rules are being revised to remove the guidelines for obtaining authorizations to provide services. Authorization requirements will be placed in the Behavioral Health Provider Manual and the rule revisions will reference the Manual. The authorization requirements are procedural in nature and are more appropriate in the context of a billing manual rather than the Agency's administrative rules.
Budget Impact – Budget neutral.
Extracted for separate vote.

Dr. Bourdeau stated she supports the collection of reliable, valid data, but has no indications the customer data core has been psychometrically tested, or that it's reliable and valid. Through the process, there have been three different behavioral health prior authorization companies. Dr. Bourdeau said that completing the CDC is not a simple process and the PA vendor changed she has had to learn a new system. Dr. Bourdeau pointed out that she did not get paid for six months and not all individual providers can afford a case manager to help them get the CDC form completed and entered. Dr. Bourdeau asked Mark Reynolds with Oklahoma DMH if she could fill out a form like that from Blue Cross/Blue Shield, which requires much less information about her services. She was informed that's not possible and she understands psychologists are resigning as OHCA providers due to this requirement. Dr. Bourdeau stated she separated out her Medicaid patients because they're became a headache. She had to do extra work and come in on weekends to complete these extra forms. Dr. Bourdeau said she feels the CDC has taken time away from her care for their patients.

Ms. Slatton-Hodges of DMH stated that over 150 agencies have used the CDC for 25 years and have mastered the system easily. As a clinician, the CDC contains data elements easily incorporated into her normal interviews. It takes her maybe 10 minutes to put it on to paper or in the computer. The data has been incredibly essential to their system, both in what they do, and how they present what they do to legislators. It is very important information that allows them to describe the people they serve. They have over 150 standard reports that providers use for therapy services and rely upon heavily. During the reprocurement process, the CDC element got hung up. The two agencies have worked together to open a portal to collect CDC information, and since that time thousands of individuals have e-mailed them. She believes the current system works successfully and is not a burden.

Dr. Crawford asked what consequence there would be if the Rule were delayed so the Behavioral Health Advisory Committee could meet one more time. Mr. Fogarty addressed the MAC and explained that on the rare occasions where we find our policy, for whatever reason, does not match our practice, we attempt to resolve these issues quickly. We now have more providers in our network across all

provider types than we have had in the history of the program. This reflects an effort that we have taken to raise provider rates and reduce the “hassle factor”. For over a year, one of the PA elements has been submission of the CDC. The CDC is considered by ODMHSAS to be an extraordinarily worthwhile set of information to collect. The CDC submission requirement was a part of the Rules section on prior authorization. With the recent removal of the outpatient prior authorization necessitated by the contractual issues, the wording regarding the CDC requirement was inadvertently removed also. That is why a reference to the CDC is not found in the current Rule. We have opted to correct the Rule instead of changing the practice. We are convinced as an agency that retaining the collection of the information on the CDC is extremely important and worthwhile. Mr. Fogarty recognized that the BHAC recommended that we wait. Mr. Fogarty said we do not have time to debate the already established practice; we do not have a choice, or we risk the loss of Federal funds. As a condition of payment, it needs to be in the code. Due to the contractual issues with our vendor we had to discontinue the PA process for a while. Since the CDC reference remains, the CDC section needs to be placed back into the Rules.

23 For, 1 Against, 1 Abstained. Mr. Tallent approved, Ms. Fritz seconded.

11-30 School Based Services – School based services rules are revised to align policy with changes to Current Procedural Terminology (CPT) coding and guidelines. Revisions will correct references to units of service and include guidelines associated with the school based services. Additionally, rules are revised to remove "Dental Screenings" and "Psychological Services" in order to clarify that these services are included within the Child Health Encounter and Psychotherapy Services, respectively, and are not separately reimbursable.
Budget Impact – Budget neutral.

11-31 Purchasing - Purchasing rules are revised to align policy with Department of Central Services (DCS) rules. Rules refer to sections that are not valid; therefore rules need to be revised to reflect new numbering for DCS policy.
Budget Impact – Budget neutral.

11-33 Insure Oklahoma - Insure Oklahoma ESI rules are revised to clarify the definition of "in-network" as being the qualified health plan's highest percentage reimbursement network approved by OHCA. The rules are also revised to clarify that OHCA only reimburses members for their out-of-pocket expenses related to services obtained from providers in the highest percentage network.
Budget Impact – Budget neutral.

11-34 Catheter Type Limitations - Rules are revised to limit the number and type of catheters covered per member per month and bring policy in line with CMS regulations on catheter utilization. Current rules allow for 150 intermittent catheters per member per month. The change will allow a combined maximum of 200 intermittent catheters per member per month. Of the 200 catheters, 60 may be the intermittent catheter with insertion supplies kit. Finally, prior authorization for these catheters will no longer be required.
Budget Impact: Budget Savings of $548,500
Extracted for separate vote. 20 For, 3 Abstain, 2 Not voted. Dr. McNeill approved. Dr. Woodward seconded.

11-35 Program of All-Inclusive Care for the Elderly (PACE) - PACE rules are revised to remove pilot specific requirements. Current language references Cherokee Nation as the PACE provider; revisions will replace specifics with general language that is applicable to any PACE provider. Additional revisions include revising the Nursing Facility Level of Care criteria to be more specific to PACE eligibility criteria and cleaning up rules for clarity.
Budget Impact – Budget neutral.

11-36 Cvek Pulpotomy and Crown Equalization - Agency dental policy is revised to allow for permanent restoration of a tooth when done as part of a Cvek Pulpotomy. The Cvek Pulpotomy is a procedure that better maintains the vitality of exposed pulps, especially in young patients. Allowing permanent restoration with the Cvek Pulpotomy will reduce the need for root canals. Finally, rules are revised to allow dentists to choose the type of crown that best serves the member's oral environment.
Budget Impact – Budget neutral.
Extracted for separate vote. Dr. Bourdeau approved. Ms. Holiman-James seconded.

Side note from Mr. Jones: Discussion on changing reference of "mental retardation" to "intellectually disabled". Mr. Rains discussed that we had discussions with our regional office and their advice was that it has not yet been changed. Mr. Fogarty stated unless there was some non-negotiable issue with the feds, we would intend to change it.

11-38 PAP Certificates of Medical Necessity - Policy is revised to remove the requirement for a certificate of medical necessity for positive airway pressure devices (BiPAP and CPAP) as such CMNs are no longer used for authorization decisions. The agency's Medical Authorization Unit and physicians rely on documentation from sleep studies and other medical records to prior authorize.
Budget Impact – Budget neutral.

11-40 Eligibility Clean-Up - Eligibility policy is revised for clarity and updates. All changes are minor and will not affect programs or budget. The revisions include changing a form number and altering punctuation to ensure the meaning and intention of the policy is clear.
Budget Impact – Budget neutral.

11-41 Mental Illness Service Program Certification – Pursuant to 43A Okla. Stat. § 3-323A, Outpatient Behavioral Health Rules are revised to add Oklahoma Department of Mental Health Substance Abuse Service (ODMHSAS) Mental Health Service Program certification as an option for provider participation standards in lieu of national accreditation.
Budget Impact - Budget neutral.

11-42 Member Sanctions - Eligibility policy is revised to address sanctioning of members who abuse SoonerCare benefits. For members who OHCA has determined to have abused their benefits, sanctions are put in place such that on the first violation, the member's eligibility will be suspended for up to six months; for the second violation, the member's eligibility will be suspend for up to twelve months; and for the third violation, the member's eligibility will be suspended indefinitely. All sanctions, including the length of the penalty period, are subject to administrative due process.
Budget Impact – Budget neutral.

A question was asked: Does OHCA notify the member's providers when this takes place? Mr. Rains replied that we go to great lengths to work with our members and before it gets to this point, have notified at least their PCP and the member, educated them, and intervened in any way we can. We work with the PCP in order to educate the member; and the PCP communicates with any referring physicians.

Dr. Crawford asked how many (members) have been sanctioned so far. We have only suspended 4 since July 2010. Most due to a very high ER utilization, and this only occurs after we have gone through intensive intervention.

11-43 Pain Management During Anesthesia - Agency anesthesia coverage policy for children is revised to allow reimbursement for a pain management procedure when performed during an anesthesia session.
Budget Impact – Budget neutral.

Approved 11-08, 11-13, 11-14, 11.29, 11-19, 11-25A&B, 11-26, 11-30, 11-31, 11-33, 11-35, 11-38, 11-40, 11-41, 11-42, 11-32A&B, Dr. McNeill approved. Ms. Bellah seconded.

OKDHS Initiated

11-32A&B OKDHS/DDSD Rule Changes - Permanent rule revisions are proposed by the OKDHS Developmental Disability Services Division (DDSD) pertaining to clarification of policy for the termination of Agency Companion providers based on certain background check information and to provide clarification on the limits of background search information for Specialized Foster Care providers regarding involvement in a court action. Additionally policy is revised to require architectural modification contractors to provide evidence of a lead based paint safety certificate; the addition of Adult Day Services for members in the Homeward Bound Waiver; Targeted Case Management to be billed weekly rather than monthly; removal of the Physical Status Review score as one of criteria for determining the enhanced rate for Community Based Group services and Job Coaching Services, and removal of Adult Day Services as an option to the member's required employment hours. Other minor policy revisions are also included.
Budget Impact – Budget neutral.

IX. New Business
Dr. Crawford welcomed the new MAC members; Ms. Brinkley, Ms. Fritz, Mr. Jones, Mr. McAdoo, Dr. McCrory, Mr. Pilgrim, Mr. Sczepanski, Ms. Stockton, and also encouraged attendance at the next MAC orientation to be scheduled at a later date. Dr. Post attended the orientation in January, and stated it was helpful and informative, even though he has been a member for several years. Dr. Post also mentioned the Board Retreat in Tulsa of last August, and encouraged the MAC members to attend this August.

Mr. Fogarty thanked the MAC members for their willingness to serve.

X. Adjourn 2:59 p.m.

Next Meeting: Wednesday, March 7, 2012.

OHCA MAC MEETING

MARCH 7, 2012 OHCA MEDICAL ADVISORY COMMITTEE MEETING

OHCA REQUEST BILLS:

- HB 2273 – Rep. Doug Cox – Allows OHCA to pay for professional expenses for OHCA CEO and Physicians; Permits Prior Authorizations for Hepatitis C and HIV prescriptions;
- SB 1161 – Sen. Gary Stanislawski – Authorizes OHCA to employ one Program Integrity auditor for every $100,000,000 expended in state and federal funds if the return on investment, including cost avoidance, is greater than the total direct and indirect costs of the employee. Program integrity auditors shall not count toward any full-time equivalent limitations on the agency.

After the February 20th deadline for Reporting Double Assigned Senate Bills from First Committee and as of noon Tuesday, February 27, 2012, the Oklahoma Legislature is tracking a total of 3,722 active bills. OHCA is currently tracking 291 bills. They are broken down as follows:

- OHCA Request 02
- Direct Impact 54
- Agency Interest 33
- Employee Interest 82
- 2011 Carryover 120+

SENATE AND HOUSE DEADLINES
Remaining Deadlines

February 27, 2012	Deadline for Single-Assigned Senate Bills in Senate Committees
March 1, 2012	Deadline for Reporting Double-Assigned Senate Bills reported from 2nd Committee and Deadline for Reporting House Bills and Joint Resolutions from House Committees
March 15, 2012	Deadline for Third Reading of a Bill in the House of Origin (House/Senate)
March 29, 2012	Deadline for Reporting Double-Assigned House Bills from lst Committee
April 5, 2012	Deadline for Reporting Single Assigned House Bills in Senate Committees
April 12, 2012	Deadline for Reporting Double-Assigned House Bills from 2nd Committee and Deadline for Reporting Senate Bills and Joint Resolutions from House Committees
April 26, 2012	Deadline for Third Reading of Bills in Opposite Chamber
May 25, 2012	Sine Die Adjournment of the Second Session of the 53rd Legislature

A Legislative Bill Tracking Report will be included in your handout at the MAC Meeting.

FINANCIAL REPORT

For the Six Months Ended December 31, 2011
Submitted to the CEO & Board
February 9, 2012

- Revenues for OHCA through December, accounting for receivables, were **$1,808,829,272** or **(.1%) under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$1,749,949,100** or **1.3% under** budget.

- The state dollar budget variance through December is **$19,733,822 positive.**

- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		6.6
Administration		4.3
Revenues:		
Taxes and Fees		3.1
Drug Rebate		4.1
Overpayments/Settlements		1.6
Total FY 12 Variance	**$**	**19.7**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2012, For the Six Months Ended December 31, 2011

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 504,654,532	$ 504,654,532	$ -	0.0%
Federal Funds	1,082,426,166	1,060,938,645	(21,487,521)	(2.0)%
Tobacco Tax Collections	28,021,493	30,928,860	2,907,367	10.4%
Quality of Care Collections	25,622,214	25,778,099	155,885	0.6%
Prior Year Carryover	55,003,490	55,003,490	-	0.0%
Federal Deferral - Interest	161,212	161,212	-	0.0%
Drug Rebates	87,137,036	98,427,243	11,290,207	13.0%
Medical Refunds	20,175,437	24,221,010	4,045,573	20.1%
Other Revenues	8,320,763	8,716,180	395,417	4.8%
TOTAL REVENUES	**$ 1,811,522,344**	**$ 1,808,829,272**	**$ (2,693,072)**	**(0.1)%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 21,971,269**	**$ 19,325,848**	**$ 2,645,421**	**12.0%**
ADMINISTRATION - CONTRACTS	**$ 60,884,454**	**$ 50,366,840**	**$ 10,517,614**	**17.3%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	16,075,966	14,857,601	1,218,365	7.6%
Acute Fee for Service Payments:				
Hospital Services	446,726,603	442,813,086	3,913,517	0.9%
Behavioral Health	156,748,158	161,257,979	(4,509,821)	(2.9)%
Physicians	219,003,392	218,367,894	635,497	0.3%
Dentists	73,449,003	73,455,181	(6,178)	(0.0)%
Other Practitioners	38,124,860	35,145,195	2,979,665	7.8%
Home Health Care	11,333,503	10,652,544	680,960	6.0%
Lab & Radiology	26,968,524	25,719,268	1,249,256	4.6%
Medical Supplies	24,018,657	23,682,457	336,200	1.4%
Ambulatory Clinics	42,250,221	40,612,807	1,637,414	3.9%
Prescription Drugs	185,547,371	186,326,929	(779,558)	(0.4)%
Miscellaneous Medical Payments	15,761,566	17,176,220	(1,414,653)	(9.0)%
OHCA TFC	-	-	-	0.0%
Other Payments:				
Nursing Facilities	246,056,594	244,917,365	1,139,229	0.5%
ICF-MR Private	29,195,534	28,157,334	1,038,200	3.6%
Medicare Buy-In	72,524,816	72,048,438	476,378	0.7%
Transportation	14,029,133	13,772,349	256,784	1.8%
EHR-Incentive Payments	34,604,750	34,604,750	-	0.0%
Part D Phase-In Contribution	37,012,238	36,689,016	323,222	0.9%
Total OHCA Medical Programs	**1,689,430,889**	**1,680,256,412**	**9,174,477**	**0.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,772,375,994**	**$ 1,749,949,100**	**$ 22,426,894**	**1.3%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 39,146,350**	**$ 58,880,172**	**$ 19,733,822**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2012, For the Six Months Ended December 31, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 15,084,224	$ 14,846,977	$ -	$ 226,623	$ -	$ 10,624	$ -
Inpatient Acute Care	395,342,726	295,572,628	243,343	6,543,183	25,157,813	1,511,411	66,314,348
Outpatient Acute Care	125,577,325	117,678,188	20,802	5,249,435	-	2,628,901	
Behavioral Health - Inpatient	59,965,262	56,673,866	-	-	-	2,658	3,288,738
Behavioral Health - Outpatient	10,208,793	10,199,271	-	-	-	-	9,522
Behavioral Health Facility- Rehab	114,250,314	92,548,534	-	240,092	-	63,811	21,397,877
Behavioral Health - Case Management	-	-	-	-	-	-	
Residential Behavioral Management	10,732,929	-	-	-	-	-	10,732,929
Targeted Case Management	28,210,906	-	-	-	-	-	28,210,906
Therapeutic Foster Care	1,769,839	1,769,839	-	-	-	-	-
Physicians	244,598,183	182,776,336	29,050	7,945,676	30,659,934	4,902,574	18,284,612
Dentists	73,491,720	69,358,856	-	36,539	4,053,473	42,853	-
Other Practitioners	35,439,072	34,416,961	223,182	293,878	489,169	15,883	-
Home Health Care	10,652,550	10,625,402	-	6	-	27,142	-
Lab & Radiology	27,313,959	25,026,156	-	1,594,691	-	693,112	-
Medical Supplies	24,069,091	22,408,246	1,237,974	386,633	-	36,237	-
Ambulatory Clinics	47,610,177	40,420,817	-	927,805	-	191,990	6,069,566
Personal Care Services	6,239,038	-	-	-	-	-	6,239,038
Nursing Facilities	244,917,365	156,663,161	68,244,155	-	19,993,733	16,317	-
Transportation	13,772,349	12,439,925	1,295,676	-	33,602	3,147	-
GME/IME/DME	72,203,159	-	-	-	-	-	72,203,159
ICF/MR Private	28,157,334	23,132,819	4,600,069	-	424,445	-	-
ICF/MR Public	28,745,706	-	-	-	-	-	28,745,706
CMS Payments	108,737,454	107,456,090	1,281,364	-	-	-	-
Prescription Drugs	195,671,597	163,823,598	-	9,344,668	21,508,947	994,383	-
Miscellaneous Medical Payments	17,176,539	16,420,976	-	319	711,750	43,493	-
Home and Community Based Waiver	79,204,958	-	-	-	-	-	79,204,958
Homeward Bound Waiver	44,481,489	-	-	-	-	-	44,481,489
Money Follows the Person	1,519,347	-	-	-	-	-	1,519,347
In-Home Support Waiver	12,001,292	-	-	-	-	-	12,001,292
ADvantage Waiver	86,662,148	-	-	-	-	-	86,662,148
Family Planning/Family Planning Waiver	3,806,253	-	-	-	-	-	3,806,253
Premium Assistance*	29,222,949	-	-	29,222,949	-	-	-
EHR Incentive Payments	34,604,750	34,604,750					
Total Medicaid Expenditures	**$ 2,231,440,796**	**$1,488,863,394**	**$ 77,175,617**	**$ 62,012,497**	**$ 103,032,866**	**$ 11,184,534**	**$ 489,171,887**

* Includes $29,052,895.01 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2012, For the Six Months Ended December 31, 2011

		FY12 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	187,343,044
Federal Funds		316,218,834
TOTAL REVENUES	**$**	**503,561,878**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	79,204,958
Money Follows the Person		1,519,347
Homeward Bound Waiver		44,481,489
In-Home Support Waivers		12,001,292
ADvantage Waiver		86,662,148
ICF/MR Public		28,745,706
Personal Care		6,239,038
Residential Behavioral Management		8,478,944
Targeted Case Management		20,627,465
Total Department of Human Services		**287,960,386**
State Employees Physician Payment		
Physician Payments		18,284,612
Total State Employees Physician Payment		**18,284,612**
Education Payments		
Graduate Medical Education		32,450,000
Graduate Medical Education - PMTC		1,954,542
Indirect Medical Education		29,677,651
Direct Medical Education		8,120,966
Total Education Payments		**72,203,159**
Office of Juvenile Affairs		
Targeted Case Management		1,324,423
Residential Behavioral Management - Foster Care		19,367
Residential Behavioral Management		2,234,618
Multi-Systemic Therapy		9,522
Total Office of Juvenile Affairs		**3,587,930**
Department of Mental Health		
Targeted Case Management		-
Hospital		3,288,738
Mental Health Clinics		21,397,877
Total Department of Mental Health		**24,686,615**
State Department of Health		
Children's First		1,058,953
Sooner Start		1,135,993
Early Intervention		2,829,824
EPSDT Clinic		1,261,561
Family Planning		39,129
Family Planning Waiver		3,739,320
Maternity Clinic		56,654
Total Department of Health		**10,121,434**
County Health Departments		
EPSDT Clinic		426,661
Family Planning Waiver		27,804
Total County Health Departments		**454,465**
State Department of Education		**68,520**
Public Schools		**2,301,722**
Medicare DRG Limit		**64,133,658**
Native American Tribal Agreements		**3,188,697**
Department of Corrections		**215,244**
JD McCarty		**1,965,446**
Total OSA Medicaid Programs	**$**	**489,171,887**
OSA Non-Medicaid Programs	**$**	**40,959,396**
Accounts Receivable from OSA	**$**	**26,569,405**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2012, For the Six Months Ended December 31, 2011

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 25,758,902	$ 25,758,902
Interest Earned	19,197	19,197
TOTAL REVENUES	**$ 25,778,099**	**$ 25,778,099**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 66,347,683	$ 23,785,644	
Eyeglasses and Dentures	144,752	51,894	
Personal Allowance Increase	1,751,720	627,992	
Coverage for DME and supplies	1,237,974	443,814	
Coverage of QMB's	516,378	185,121	
Part D Phase-In	1,281,364	1,281,364	
ICF/MR Rate Adjustment	2,448,365	877,739	
Acute/MR Adjustments	2,151,705	771,386	
NET - Soonerride	1,295,676	464,500	
Total Program Costs	**$ 77,175,617**	**$ 28,489,454**	**$ 28,489,454**
Administration			
OHCA Administration Costs	$ 273,774	$ 136,887	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	2,500	1,250	
Total Administration Costs	**$ 276,274**	**$ 138,137**	**$ 138,137**
Total Quality of Care Fee Costs	**$ 77,451,891**	**$ 28,627,591**	
TOTAL STATE SHARE OF COSTS			**$ 28,627,591**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2012, For the Six Months Ended December 31, 2011

REVENUES	FY 11 Carryover	FY 12 Revenue	Total Revenue
Prior Year Balance	$ 21,470,039	$ -	$ 18,206,511
State Appropriations			
Tobacco Tax Collections	-	25,438,016	25,438,016
Interest Income	-	263,841	263,841
Federal Draws	4,432,268	19,360,372	19,360,372
All Kids Act	(7,396,736)	145,895	145,895
TOTAL REVENUES	$ 18,505,571	$ 45,208,125	$ 63,268,741

EXPENDITURES	FY 11 Expenditures	FY 12 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 28,705,983	$ 28,705,983
College Students		170,054	170,054
All Kids Act		346,912	346,912
Individual Plan			
SoonerCare Choice	$ 220,395	$ 79,012	
Inpatient Hospital	6,522,454	2,338,300	
Outpatient Hospital	5,186,733	1,859,444	
BH - Inpatient Services	-	-	
BH Facility - Rehabilitation Services	238,988	85,677	
Physicians	7,882,406	2,825,843	
Dentists	29,564	10,599	
Other Practitioners	286,795	102,816	
Home Health	6	2	
Lab and Radiology	1,573,443	564,079	
Medical Supplies	378,593	135,726	
Ambulatory Clinics	918,462	329,269	
Prescription Drugs	9,244,942	3,314,312	
Miscellaneous Medical	-	-	
Premiums Collected	-	(1,174,461)	
Total Individual Plan	$ 32,482,781	$ 10,470,616	
College Students-Service Costs	$ 262,677	$ 94,170	
All Kids Act- Service Costs	$ 60,047	$ 21,527	
Total Program Costs	$ 62,028,455	$ 39,809,262	
Administrative Costs			
Salaries	$ 13,534	$ 789,490	$ 803,024
Operating Costs	29,081	69,334	98,415
Health Dept-Postponing	-	-	-
Contract - HP	256,445	1,235,094	1,491,538
Total Administrative Costs	$ 299,059	$ 2,093,918	$ 2,392,977
Total Expenditures			$ 42,202,239
NET CASH BALANCE	$ 18,206,511		$ 21,066,502

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund

Fiscal Year 2012, For the Six Months Ended December 31, 2011

REVENUES	FY 12 Revenue	State Share
Tobacco Tax Collections	$ 507,665	$ 507,665
TOTAL REVENUES	**$ 507,665**	**$ 507,665**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 10,624	$ 2,667	
Inpatient Hospital	1,511,411	379,364	
Outpatient Hospital	2,628,901	659,854	
Inpatient Free Standing	2,658	667	
MH Facility Rehab	63,811	16,016	
Case Mangement	0	-	
Nursing Facility	16,317	4,096	
Physicians	4,902,574	1,230,546	
Dentists	42,853	10,756	
Other Practitioners	15,883	3,987	
Home Health	27,142	6,813	
Lab & Radiology	693,112	173,971	
Medical Supplies	36,237	9,096	
Ambulatory Clinics	191,990	48,190	
Prescription Drugs	994,383	249,590	
Transportation	3,147	790	
Miscellaneous Medical	43,493	10,917	
Total Program Costs	$ 11,184,534	$ 2,807,318	**$ 2,807,318**
TOTAL STATE SHARE OF COSTS			**$ 2,807,318**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

SoonerCare Programs

December 2011 Data for February 2012 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2011	Enrollment December 2011	Total Expenditures December 2011	Average Dollars Per Member Per Month December 2011
SoonerCare Choice Patient-Centered Medical Home			449,392	**477,285**	**$121,716,040**	
	Lower Cost	*(Children/Parents; Other)*		432,213	$85,209,094	$197
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		45,072	$36,506,946	$810
SoonerCare Traditional			239,274	**231,335**	**$176,788,032**	
	Lower Cost	*(Children/Parents; Other)*		124,378	$56,594,420	$455
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		106,957	$120,193,613	$1,124
SoonerPlan			31,082	**40,682**	**$704,518**	$17
Insure Oklahoma			32,181	**31,624**	**$9,250,783**	
	Employer-Sponsored Insurance		19,095	17,747	$4,462,987	$251
	Individual Plan		13,085	13,877	$4,787,796	$345
TOTAL			**751,928**	**780,926**	**$308,459,374**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $103,311,423 are excluded.

Net Enrollee Count Change from Previous Month Total	(477)

New Enrollees	17,585

Opportunities for Living Life (OLL) (subset of data above)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,363
Aged/Blind/Disabled	*Adult*	130,816
Other	*Child*	173
Other	*Adult*	20,467
PACE	*Adult*	85
TEFRA	*Child*	412
Living Choice	*Adult*	95
OLL Enrollment		**171,411**

The "Other" category includes DDSD State, PKU, Q1, Q2, Refugee, SLMB, Soon-to-be-Sooners (STBS) and TB members.

Medicare and SoonerCare	Monthly Average SFY2011	Enrolled December 2011
Dual Enrollees	**103,906**	**107,909**

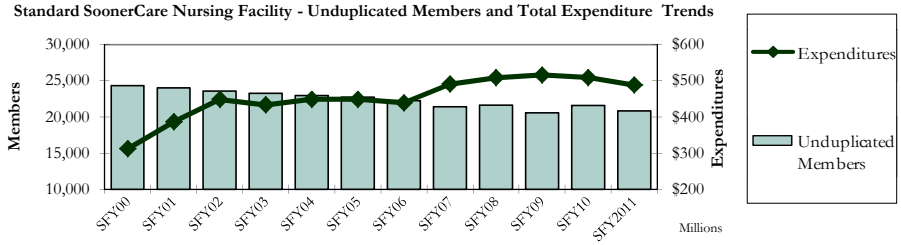
		Monthly Average SFY2011	Enrolled December 2011	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,759**	**$3,138**
	Child	92	88	
	Adult	15,641	15,671	

SFY2011 Long-Term Care

Statewide LTC Occupancy Rate - 71.0%
SoonerCare funded LTC Bed Days 68.2%

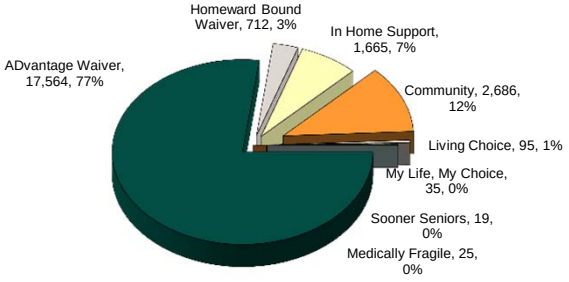
Data as of October 2011

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Aug. 8, 2011. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

Waiver Enrollment Breakdown Percent



ADvantage Waiver - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.
Community - serves individuals 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded/intellectually disabled (ICF/MR).
Homeward Bound Waiver - Designed to serve the needs of individuals with intellectual disabilities or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/MR.
In Home Support - Serves the needs of individuals 3 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/MR.
Living Choice - Promotes community living for people of all ages who have disabilities or long-term illnesses.
Medically Fragile - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.
My Life, My Choice - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.
Sooner Seniors - This program is for adults 65 and older with long term illnesses who transitioned to community-based services in the Living Choice program.

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2011	Enrolled December 2011
Total Providers		**29,026**	**38,234**
	In-State	20,585	28,156
	Out-of-State	8,442	10,078

Program	% of Capacity Used
SoonerCare Choice	38%
SoonerCare Choice I/T/U	13%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled December 2011***	Total Monthly Average SFY2011	Total Enrolled December 2011
Physician	*6,489*	*7,628*	*11,777*	13,701
Pharmacy	*901*	*872*	*1,230*	1,152
Mental Health Provider***	*935*	*3,849*	*982*	3,906
Dentist	*798*	*987*	*901*	1,123
Hospital	*187*	*195*	*739*	933
Licensed Behavioral Health Practitioner***	*503*	*3,358*	*524*	3,392
Extended Care Facility	*392*	*373*	392	373

*The In-State Monthly Averages above were recalculated due to a change in the original methodology.

Total Primary Care Providers	*4,461*	*4,833*	6,467	6,692
Patient-Centered Medical Home	*1,476*	*1,736*	1,502	1,763

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

**Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

***Due to federal regulations, OHCA must have an approved agreement on file for all providers providing care to our members. To meet this requirement OHCA is directly contracting with providers that had previously billed through a group or agency. This contributed to the increase in the provider counts for Licensed Behavioral Health Practitioners and Mental Health Providers.

SOONERCARE HEALTH STATUS

SFY2011 Delivery and Related Services		
Total women with a delivery	**31,961**	**5.72% of women enrolled**
Total Delivery Costs	**$134,197,436**	**average $4,190**
Women with prenatal visits	31,186	97% of total
Total paid for prenatal care*	$47,860,292	average $1,535
Women with postpartum visits	25,866	81% of total
Total paid for postpartum care*	$540,988	average $21
Total prenatal, delivery, and postpartum	**$182,598,716**	**average $5,700**

*Providers may bill a bundled code that includes prenatal, delivery and postpartum services. Bundled payments are included in the delivery costs.

SFY2011 Delivery Cost and Percent

*Bundled payments are included in the delivery costs.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

As Of 2/6/2012	January 2012		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	13	$276,250	1,057	$22,475,417
Eligible Hospitals	3*	$1,312,622	69	$50,087,837
Totals	16	$1,588,872	1,126	$72,563,254

*Current Eligible Hospitals Paid
CHEROKEE NATION - WW HASTINGS
CLAREMORE IND HSP
CORDELL MEMORIAL HOSPITAL

SoonerCare Programs

December 2011 Data for February 2012 Board Meeting

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TOTAL			**751,928**	**780,926**	**$308,459,374**	

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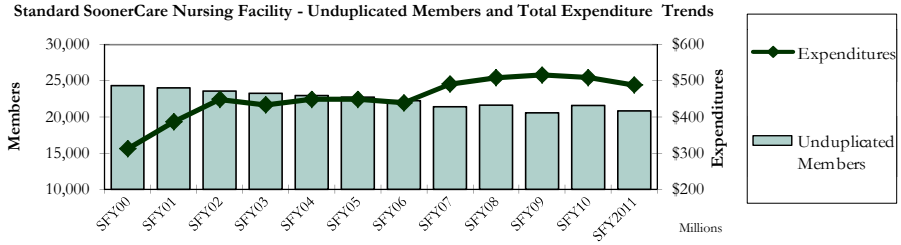

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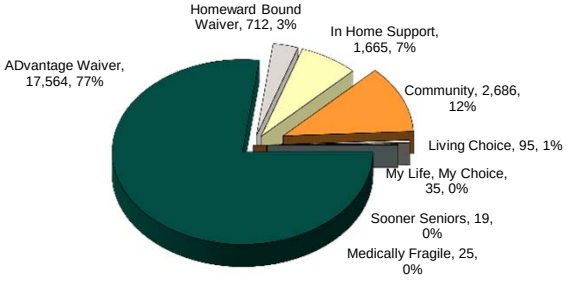

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SoonerCare Programs

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Dentist	*798*	*987*	*901*	1,123
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Total Primary Care Providers	*4,461*	*4,833*	6,467	6,692
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Including Physicians, Physician Assistants and Advance Nurse Practitioners.

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Total Delivery Costs	**$134,197,436**	**average $4,190**
Women with prenatal visits	31,186	97% of total
Total paid for prenatal care*	$47,860,292	average $1,535
Women with postpartum visits	25,866	81% of total
Total paid for postpartum care*	$540,988	average $21
Total prenatal, delivery, and postpartum	**$182,598,716**	**average $5,700**

*Providers may bill a bundled code that includes prenatal, delivery and postpartum services. Bundled payments are included in the delivery costs.

SFY2011 Delivery Cost and Percent

*Bundled payments are included in the delivery costs.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

As Of 2/6/2012	January 2012		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	13	$276,250	1,057	$22,475,417
Eligible Hospitals	3*	$1,312,622	69	$50,087,837
Totals	16	$1,588,872	1,126	$72,563,254

*Current Eligible Hospitals Paid
CHEROKEE NATION - WW HASTINGS
CLAREMORE IND HSP
CORDELL MEMORIAL HOSPITAL

OHCA Child Health Presentations

ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS ANNUAL CONFERENCE

FEBRUARY 2012

oklahoma health care authority

MAC Presentation 3.07.2012

Shelly Patterson, MPH

PANEL: OPTIMIZING HEALTH REFORM TO IMPROVE MATERNAL & INFANT HEALTH OUTCOMES

WORKSHOP PRESENTATION

OKLAHOMA PARTNERSHIP

Suzanna Dooley, M.S., A.P.R.N.,C.N.P.
Title V MCH Director
Oklahoma State Department of Health

Shelly Patterson, M.P.H.
Director of Child Health
Oklahoma Health Care Authority

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INTERAGENCY COLLABORATION

- Agencies established a joint Perinatal Advisory Task Force in 2005
- Assists both agencies in developing improved policies and services

POLICY CHANGE

- Prenatal risk assessment
- First trimester ultrasounds
- Perinatal dental
- Maternal and infant health social work services
- Lactation consultation services
- Genetic counseling services
- Soon-to-be-Sooners
- Tobacco cessation counseling
- Title V needs assessment/priorities

FEATURED ACTIVITIES

- Shared Data Workgroup
- OHCA Fetal/Infant Mortality Project
- Preparing for a Lifetime, It's Everyone's Responsibility
- Tobacco cessation
  - SoonerQuit Prenatal
  - SoonerQuit for Women

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ONGOING COLLABORATION

- OSDH Maternal and Child Health Service
- Oklahoma Health Care Authority
- Office of Perinatal Quality Improvement
- March of Dimes
- Oklahoma Hospital Association
- Oklahoma Institute for Child Advocacy
- Oklahoma Family Network

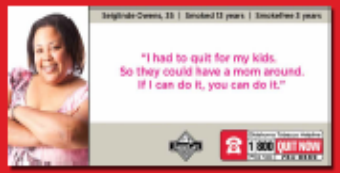
LESSONS SHARED

- Reach out – take the initiative
- Identify common problems/needs
- Relationships, Relationships, Relationships
- Listen to one another
- Be open to change
- Understand that it won't always be a group hug; you will not always agree
- Do not be static, constantly assess needs

SOONERQUIT POSTER

FEBRUARY 2012

SHELLY PATTERSON, MPH & DARYN KIRKPATRICK, BA



SoonerQuit

Oklahoma's state agency collaboration to reduce tobacco use in women of child-bearing age

Shelly Patterson, MPH and Daryn Kirkpatrick, BA

Tobacco use remains the single most preventable cause of death and poor health outcomes in the U.S. In Oklahoma, tobacco use rates are well above the 19.3% national average, ranking third highest in the nation at 23.7%. Tobacco cessation among women of child-bearing age is a critical factor in positively impacting the health of families across the life span.

One of the key components of Oklahoma's comprehensive plan for tobacco cessation is a collaborative approach among multiple state agencies to create a systems level change for sustainability. In 2010, Oklahoma's Medicaid agency, the Oklahoma Health Care Authority (OHCA) partnered with the Oklahoma State Department of Health (OSDH) and the Oklahoma Tobacco Settlement Endowment Trust (TSET) to implement two new initiatives to promote tobacco cessation among women of child-bearing age. The "SoonerQuit" tobacco cessation program focuses on improving birth outcomes of pregnant women covered by SoonerCare (Oklahoma's Medicaid program) as well as long term health outcomes for women and their families.

SoonerQuit Prenatal

Purpose

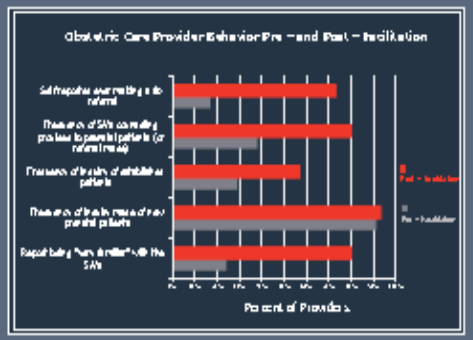
To improve Oklahoma birth outcomes via systemic change in obstetric care provider behavior through education and hands-on technical assistance of evidence-based tobacco cessation practices.

Methods

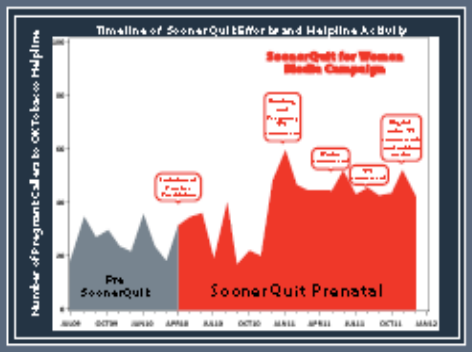
Practice Facilitation model. A trained public health professional works in the practice full time for several weeks to gain a full understanding of daily operations. Provider and office staff receive education and direct technical assistance to integrate best practices into the daily routine. Practice facilitator provides follow-up and support for six months after completion of initial facilitation.

Objectives

The long term impact of this initiative is to improve birth outcomes by reducing rates of tobacco use during pregnancy and postpartum. Expected outcomes include increases in obstetric care providers' knowledge and routine use of 5A's tobacco cessation counseling, rates of inquiry of tobacco use and referrals to the Oklahoma Tobacco Helpline.



There was a 36% increase in the number of pregnant women using the OKTobacco Helpline during FY11 as compared to FY10



SoonerQuit for Women

Purpose

To decrease the tobacco use rate among women of child bearing age, particularly those with low socioeconomic status, via a statewide media campaign promoting the SoonerQuit tobacco cessation program and the Oklahoma Tobacco Helpline.

Methods

Statewide marketing campaign featuring stories of Oklahoma women who have successfully quit smoking. Initiated by campaign designed to recruit potential "real life" women of diverse ethnicity between the ages of 20 and 36 who successfully quit smoking in the last one to three years. Recruitment materials directed women to call a toll free number to be interviewed and vetted. Mass media ran in the Oklahoma City and Tulsa metropolitan newspapers, transit, radio, and through various social media outlets for several weeks. Six stories were selected for use in the statewide campaign with unscripted personal stories in their own voice about how and why they quit, and life after cigarettes. Media has included television, print, radio and transit ads. Products were shared with other statewide partners for potential additional placement and marketing.

Objective

The long term objective of this initiative is to decrease the prevalence of tobacco use among Oklahoma women of child bearing age and low socioeconomic status. Expected outcomes include increased use of tobacco cessation benefits by women insured through SoonerCare (counseling and pharmacotherapy) and increases in use of the Oklahoma Tobacco Helpline by low SES women, 18-49 years of age.

This initiative was made possible through funding from the Oklahoma Tobacco Settlement Endowment Trust

References: CDC MMWR 2011; Oklahoma State Department of Health 2010; SoonerQuit SFY 2011 Evaluation Narrative Report

"SOONERQUIT"

- Official trademark name for
  SoonerCare tobacco cessation services and programs
- Partnership Initiatives with TSET
  - SoonerQuit Prenatal
  - SoonerQuit for Women

SOONERQUIT PRENATAL

Goal:

Improve birth outcomes for Oklahoma babies by reducing tobacco use among pregnant SoonerCare members

PARTNERS

- Oklahoma Health Care Authority
- OK Tobacco Settlement Endowment Trust
- OK State Department of Health
- OK Tobacco Helpline
- Telligen
- Pacific Health Policy Group
- Perinatal Advisory Taskforce

Creating a State of Health

Oklahoma Tobacco Helpline 1 800 QUIT NOW

TSET BETTER LIVES THROUGH BETTER HEALTH

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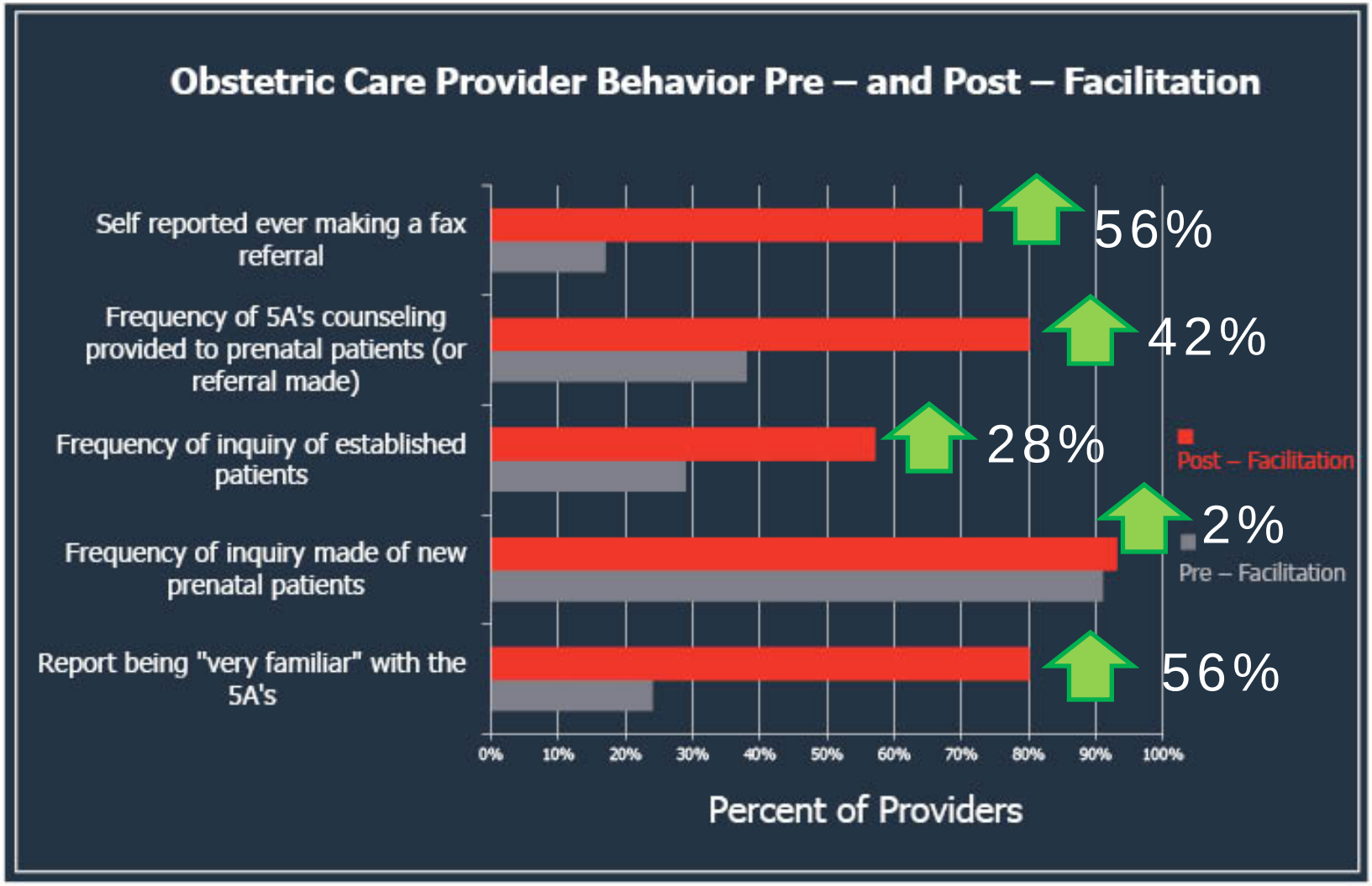
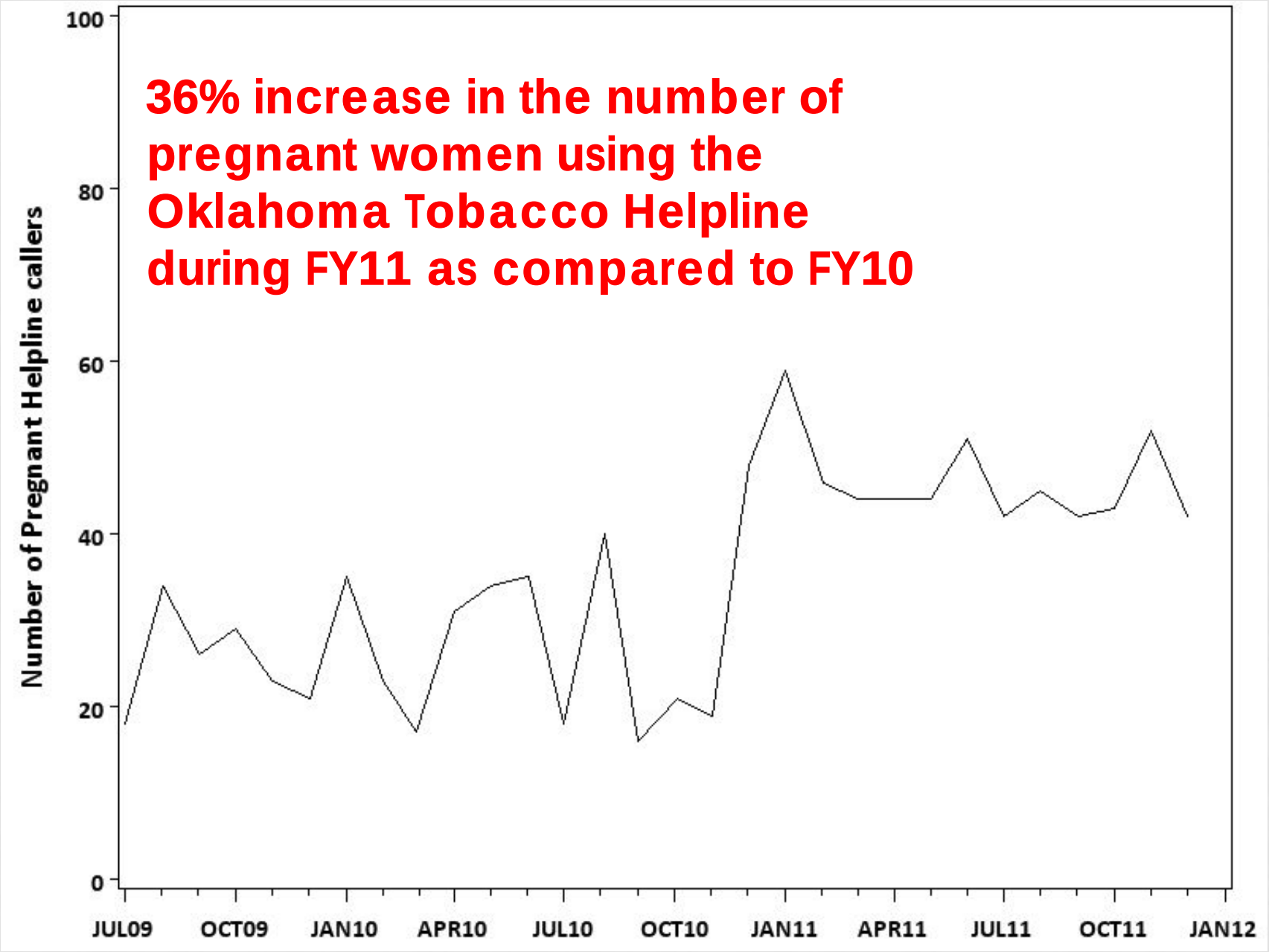
THE PACIFIC HEALTH POLICY GROUP

SQ PRENATAL OBJECTIVES

Increase prenatal care provider:

- Knowledge and use of best practices for tobacco cessation
- Rate of inquiry about tobacco use status of pregnant patients
- Routine use of 5A's tobacco cessation counseling
- Rate of referrals to the Oklahoma Tobacco Helpline


Obstetric Care Provider Behavior Pre – and Post – Facilitation
Self reported ever making a fax referral
Frequency of 5A's counseling provided to prenatal patients (or referral made)
Frequency of inquiry of established patients
Frequency of inquiry made of new prenatal patients
Report being "very familiar" with the 5A's
56%
42%
28%
2%
56%
Post – Facilitation
Pre – Facilitation
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Percent of Providers


36% increase in the number of pregnant women using the Oklahoma Tobacco Helpline during FY11 as compared to FY10
Number of Pregnant Helpline callers
100
80
60
40
20
0
JUL09
OCT09
JAN10
APR10
JUL10
OCT10
JAN11
APR11
JUL11
OCT11
JAN12

SOONERQUIT FOR WOMEN

- Collaboration between TSET, OHCA and OSDH to promote SoonerQuit benefits and the Oklahoma Tobacco Helpline
- Goal—To decrease the prevalence of tobacco use among Oklahoma women of child-bearing age (18-49) and low socioeconomic status.
- Strategy--Statewide marketing campaign and local promotion of stories of Oklahoma women of child-bearing age who successfully quit smoking in the last one to three years

SOONERQUIT FOR WOMEN

Mary Trail, 28 | Smoked 9 years | Smokefree 2

"When I said no to the urge to smoke,
I was proud.
It was like giving myself a pat on the back."

Oklahoma Tobacco Helpline 1 800 QUIT NOW Free help 784-8669

Seiglinde Owens, 35 | Smoked 13 years | Smokefree 3 years

"I had to quit for my kids.
So they could have a mom around.
If I can do it, you can do it."

Oklahoma Tobacco Helpline 1 800 QUIT NOW Free help 784-8669

Sonny Mac, 35 | Smoked 10 years | Smokefree 4 years

"Live your life. Enjoy your life. There are so many other things
that you can enjoy besides picking up a cigarette.
Life is so much more than that."

Oklahoma Tobacco Helpline 1 800 QUIT NOW Free help 784-8669

SOONERQUIT FOR WOMEN

Bridgette Hennings, 26 | Smoked 10 years | Smokefree 2 years

"I picked a date, and I said, I'm gonna do it.
I'm gonna take this day to change my life. And I did.
You can quit smoking. Just believe in yourself."

Oklahoma Tobacco Helpline 1 800 QUIT NOW Free help 784-8669

Kendra Flanagan, 27 | Smoked 8 years | Smokefree 3 years

"Don't give up on quitting smoking.
I am healthier.
My family is healthier."

Oklahoma Tobacco Helpline 1 800 QUIT NOW Free help 784-8669

Taryn Goodwin, 26 | Smoked 8 years | Smokefree 3 years

"It starts today. You don't have to wait.
You can quit smoking now."

Oklahoma Tobacco Helpline 1 800 QUIT NOW Free help 784-8669

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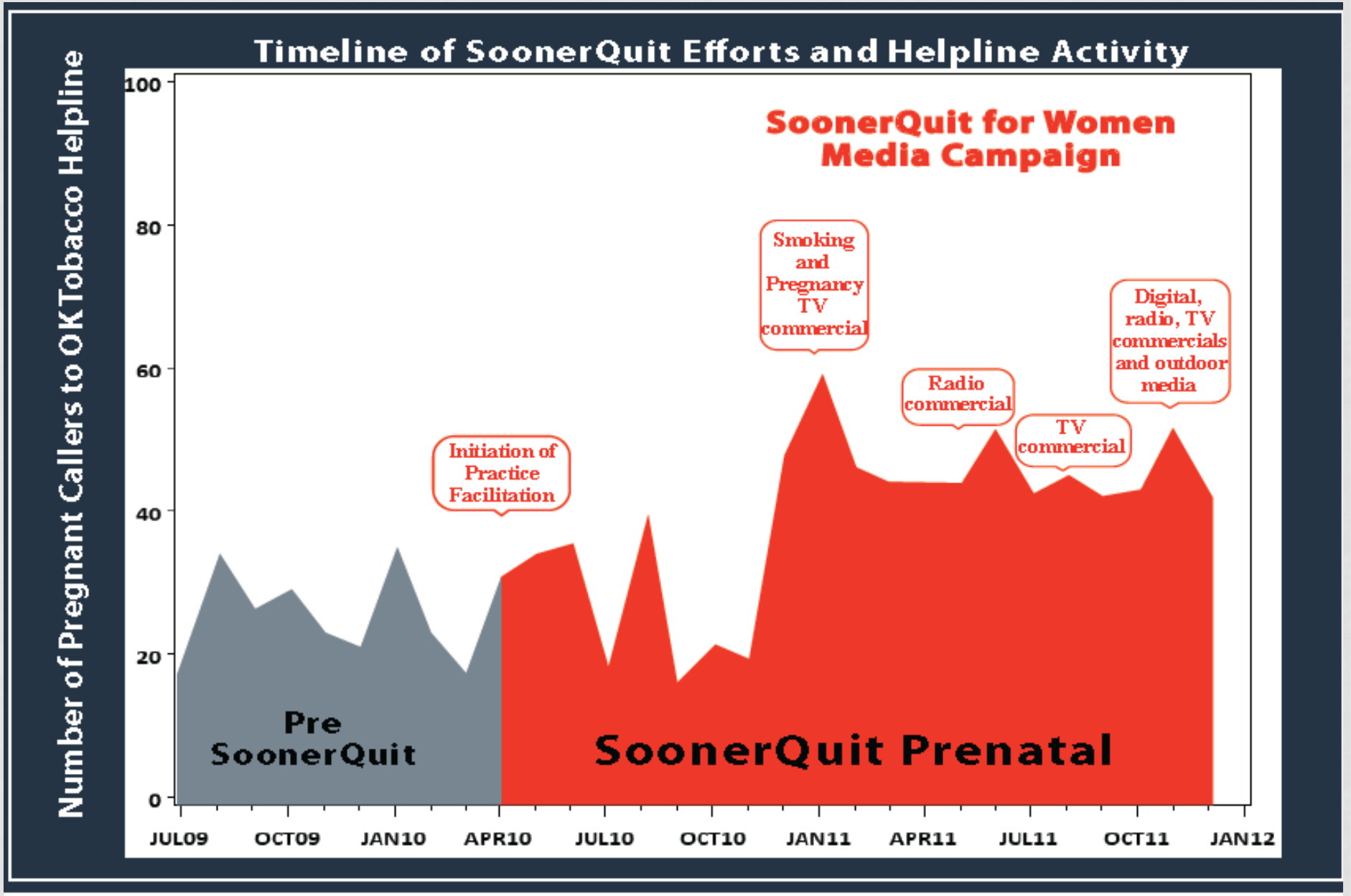
MEDIA PROMOTION

9427_Taryn_Goodwin_R60_Tag3[1].mp3

9427_Kristi_Clemens_R60_Tag3REV.mp3

v04_10062_Heart_Attack_OTH_tag1a.mov


Timeline of SoonerQuit Efforts and Helpline Activity
Number of Pregnant Callers to OKTobacco Helpline
100
80
60
40
20
0
SoonerQuit for Women Media Campaign
Smoking and Pregnancy TV commercial
Digital, radio, TV commercials and outdoor media
Radio commercial
TV commercial
Initiation of Practice Facilitation
Pre SoonerQuit
SoonerQuit Prenatal
JUL09
OCT09
JAN10
APR10
JUL10
OCT10
JAN11
APR11
JUL11
OCT11
JAN12

QUESTIONS?

FETAL INFANT MORTALITY REDUCTION:

Targeted Care Management for Oklahoma Mothers & Their Infants

Marlene Asmussen, RN, Director of CM, HMP & MAU

Rebekah Gossett, RN, Care Management Supervisor, FIMR Project Lead

BACKGROUND

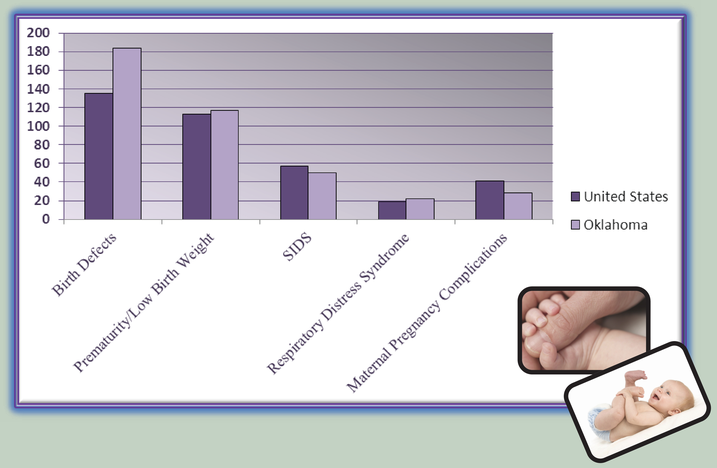
Oklahoma ranked 46th in the U.S. with an infant mortality rate (IMR) of 8.5 in 2007. Oklahoma's IMR has remained above the national rate since 1992. While some improvements have been observed, the state's IMR of 8.5 deaths per 1,000 live births for 2007; Oklahoma is no better than the national average of 8.5 achieved more than 15 years earlier (OSDH).

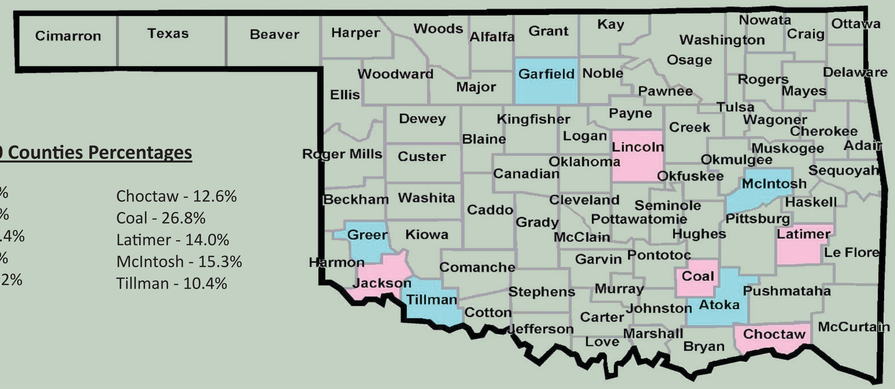
Oklahoma's IMR is associated with:

- Maternal health
- Quality and access to medical care
- Socioeconomic conditions
- Public health practices

The top three causes of infant mortality in Oklahoma are:

- Congenital defects
- Disorders related to low birth weight and short gestation
- Sudden Infant Death Syndrome & unsafe sleep practices





Top 10 Counties Percentages

Atoka - 10.8%
Lincoln - 9.9%
Garfield - 10.4%
Greer - 12.7%
Jackson - 10.2%
Choctaw - 12.6%
Coal - 26.8%
Latimer - 14.0%
McIntosh - 15.3%
Tillman - 10.4%

METHODS

In response to this need, Oklahoma Health Care Authority Care Management Division conducts targeted telephonic care management for all pregnant women in the top 10 counties with the highest IMR rates. OHCA Care Management initiates contact with pregnant women in these 10 counties the week after they apply for SoonerCare benefits. We care manage these women with tiered targeted assessments/call scripts through the end of their pregnancy. After delivery, OHCA care managers continue educational outreach with the member through her infant's first year of life.

OHCA Care Management Partners

- Oklahoma State Department of Health
- OHCA Child Health Division
- OHCA Behavioral Health Division
- Statewide home visitation programs

Resources

- Prescription for a Healthy Future*
- Smoking & Pregnancy*
- Facts About Preterm Birth*
- Your Baby's Safety*
- Safe Sleep for Your Baby*
- Nursing Your Newborn*
- Recognizing Postpartum Depression*

*Resources can be found on Oklahoma State Department of Health's website:
http://www.ok.gov/health/Child_and_Family_Health/Improving_Infant_Outcomes/Free_Materials_&_Resources/index.html

EDUCATIONAL TOPICS

Prenatal Education

- First pregnancy vs. subsequent pregnancy
- Tobacco usage in the home (mom and/or another person)
- Utilization of WIC
- Intent to breastfeed vs. bottle feed
- Provision of resources concerning breastfeeding
- Candidate for the High Risk OB Program enhanced benefit review
- Gestational Diabetes
- Special dietary concerns
- Female infections
- Blood pressure problems
- Domestic violence screening
- Choosing a medical provider for the baby
- Safe sleep education
- Baseline depression screening and EPDS screening 2-3 weeks after delivery

Postpartum

- Enrollment of the infant on SoonerCare
- Tobacco usage in the home (mom and/or another person)
- Breastfeeding resources/concerns
- Car seat
- Immunization and Well Child appointment schedule
- Safe sleep education

NUMBER OF CASES SINCE INCEPTION

FIMR By The Numbers (Mother)
March 21, 2011 to January 20, 2012

2079	Cumulative Cases to Date
82.56	% of Cases Remain Active
119	Number of Fetal Demise Cases

FIMR By The Numbers (Baby)
August 22, 2011 to January 20, 2012

836	Cumulative Cases to Date
96.0	% of Cases Remain Active

DME REUSE PROGRAM

OKDMERP (Oklahoma Durable Medical Equipment Reuse Program) is operational as of March 5, 2012. The address is 3325 North Lincoln Oklahoma City, OK 73105.

Proposed Waiver Applications, Renewals and Amendments

Circulated Date	Waiver Application/Amendment	Waiver Program	OHCA Comment Due Date
02/17/2012	In-Home Supports Waiver for Adults Renewal Feedback Form	In-Homes Supports Waiver for Adults	03/19/2012
02/17/2012	In-Home Supports Waiver for Children Renewal Feedback Form	In-Homes Supports Waiver for Children	03/19/2012

If you have questions or comments, please contact:

M. Melinda Jones
melinda.jones@okhca.org
405 522 7125 (p)
405 530 3281 (f)

Director, Waiver Administration
Oklahoma Health Care Authority
2401 NW 23rd St., Suite 1-A
Oklahoma City, OK 73107

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

Adults with disabilities or long-term illnesses, members with mental retardation and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in an institution (nursing facility or public ICF/MR) for at least 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

(8) He/she must not be a resident of a nursing facility or ICF/MR in lieu of incarceration.

317:35-23-3. Participant ~~disenrollment~~ dis-enrollment

(a) ~~Members are~~ A member is ~~disenrolled~~ dis-enrolled from the program if he/she:

(1) is admitted to a hospital, nursing facility, ICF/MR, residential care facility or behavioral health facility for more than 30 consecutive days;

(2) is incarcerated;
(4) is determined to no longer meet SoonerCare financial eligibility for home and community based services;
(5) determined by the Social Security Administration or OHCA Level of Care Evaluation Unit to no longer have a disability that qualifies for services under the Living Choice program; or
(6) moves out of state.

(b) Payment cannot be made for an individual who is in imminent danger of harm to self or others.

317:35-23-4. Re-enrollment

(a) **Members in the Living Choice Program.**

(1) The member remains eligible during periods of institutionalization as long as the stay does not exceed 30 days.

~~(a)~~ (2) A member with an institutional stay longer than 30 days may re-enroll in the program without ~~residing in an institution for the six months prior~~ re-establishing the 90 day institutional residency requirement if:

~~(1)~~ (A) the necessity for the institutionalization is documented in the revised individual transition plan; and

~~(2)~~ (B) the member can safely return to the community as determined by the transition coordinator, the member and the transition planning team.

(3) The re-enrolled member is eligible to receive services for any remaining days up to the 365 day limit.

~~(b) The member remains eligible during hospitalization and convalescent care periods as long as the stay does not exceed six months~~.

(b) **Members no longer in the Living Choice Program.**

(1) Members who have completed 365 days in the Living Choice Program and have been re-institutionalized for a minimum of 90 consecutive days may be eligible for re-enrollment in the Living Choice Program. Before re-enrollment of a former member, a re-evaluation of the former member's plan of care must be completed and a determination made if the plan of care could not be carried out as a result of:

(A) medical and/or behavioral changes resulting in the necessity of readmission into the inpatient facility;

(B) the lack of community services to support the member that were identified in the original plan of care; or

(C) the plan of care was not supported by the delivery of quality services.

(2) After determining the basis for re-institutionalization and creation of a new plan of care that ensures the health and safety of the former member, he/she may be re-enrolled for an additional 365 days.

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable

case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in Oklahoma Department of Human Services/Aging Services Division (OKDHS/ASD) identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(3) **Adult Day Health Care.**

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the member. Physical, occupational, and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. ~~Transportation between the member's residence and the service setting is provided as a part of Adult Day Health Care.~~ Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing and/or hair washing will be authorized when an ADvantage waiver member who uses adult day health care requires assistance with bathing and/or hair washing to maintain health and safety.

(B) Adult Day Health Care is a 15-minute unit. No more than 6 hours are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

(4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or

improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent. All services must be prior authorized.

(6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(7) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and

continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member. (B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The ADvantage Program case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the ADvantage Program case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and

monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of

units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy Services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(10) **Physical Therapy Services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a

licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) **Speech and Language Therapy Services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice care. ADvantage Hospice Care is

authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of ADvantage Hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(13) **ADvantage Personal Care.**

(A) ADvantage Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental

activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) ADvantage Home Care Agency Skilled Nursing staff working in coordination with an ADvantage Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) ADvantage Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

(14) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase

of PERS. All services are prior authorized in accordance with the ADvantage approved plan of care.

(15) **Consumer-Directed Personal Assistance Services and Support (CD-PASS).**

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing these employer functions. The member:

(i) recruits, hires and, as necessary, discharges the PSA or APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASPA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:

(i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming;

(III) eating including meal preparation and cleanup;
(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;
(iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

(C) Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

(i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
(ii) remove external catheters, inspect skin and reapplication of same;
(iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with members without contraindicating rectal or intestinal conditions;
(iv) apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
(v) use lift for transfers;
(vi) manually assist with oral medications;
(vii) provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of

care, unless contraindicated by underlying joint pathology;

(viii) apply non-sterile dressings to superficial skin breaks or abrasions; and

(ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Financial Management Services are program administrative services provided to participating CD-PASS employer/members by the OKDHS/ASD. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

(v) for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards.

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

(16) **Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the

institution and receive necessary support through ADvantage waiver services in their home and/or in the community.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received ADvantage services but have been referred by the OKDHS/ASD to the Case Management Provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution Transition Case Management services are prior authorized and billed per 15-minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the member served as described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institutional Transition Services may be authorized and reimbursed under the following conditions:

(i) The service is necessary to enable the individual to move from the institution to their home;

(ii) The individual is eligible to receive ADvantage services outside the institutional setting;

(iii) Institutional Transition Services are provided to the individual within 180 days of discharge from the institution;

(iv) Transition Services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(D) If the member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services provided are not reimbursable.

(17) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance (to the extent permitted under State law). The assisted living services provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center. Nursing services are incidental rather than integral to the provision of assisted living services. ADvantage reimbursement for Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the participant as determined through individualized assessment and documented on the participant's service plan.

(B) The ADvantage Assisted Living Services philosophy of service delivery promotes service member choice, and to the greatest extent possible, service member control. Members have control over their living space and choice of personal amenities, furnishing and activities in their residence. The Assisted Living Service provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery that emphasizes member dignity, privacy, individuality, and independence.

(C) ADvantage Assisted Living required policies for Admission/Termination of services and definitions.

(i) ADvantage-certified Assisted Living Centers (ALCs) are required to accept all eligible ADvantage members who choose to receive services through the ALC subject only to issues relating to:

(I) unit availability;

(II) the compatibility of the participant with other residents; and

(III) the center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage participants.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate individuals who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage Case Manager, the member and/or member's designated representative and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy and dignity. Inability to meet those needs will not be recognized as a reason for determining that an ADvantage participant's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the description of assisted living center services in the Oklahoma State Department of Health regulations (OAC 310:663-3-3) except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the following services:

(I) Provide an emergency call system for each participating ADvantage member;

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to members' needs and choices; and

(III) Arrange or coordinate transportation to and from medical appointments.

(vi) The provider may offer any specialized service or unit for residents with Alzheimer's disease and related dementias, physical disabilities or other special needs that the facility intends to market.

(vii) If the provider arranges and coordinates services for members, the provider is obligated to assure the provision of those services.

(viii) Under OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or

other personal needs or maintenance, or general supervision of the physical and mental well-being of a person". For ADvantage Assisted Living Services, assistance with "other personal needs" in this definition includes assistance with toileting, grooming and transferring and the term "assistance" is clarified to mean hands-on help in addition to supervision.

(ix) The specific Assisted Living Services assistance provided along with amount and duration of each type of assistance is based upon the individual member's assessed need for service assistance and is specified in the ALC's service plan which is incorporated as supplemental detail into the ADvantage comprehensive service plan. The ADvantage Case Manager in cooperation with the Assisted Living Center professional staff develops the service plan to meet member needs. As member needs change, the service plan is amended consistent with the assessed, documented need for change in services.

(x) Definition of Inappropriate ALC Placement. Placement or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the following conditions exist:

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs;

(II) The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well being of other residents and the ALC has documented efforts to resolve behavior problems including medical interventions, behavioral interventions and increased staffing interventions. Documentation must support that ALC attempted interventions to resolve behavior problems;

(III) The member has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed and implemented in the assisted living environment. Documentation must support that ALC attempted to obtain appropriate care for the member; or

(IV) The member fails to pay room and board charges and/or the OKDHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the assisted living center must inform the member and/or the member's representative, if any, and the member's ADvantage Case Manager. The ALC

must develop a discharge plan in consultation with the member, the member's support network and the ADvantage Case Manager. The ALC and Case Manager must ensure that the discharge plan includes strategies for providing increased services, when appropriate to minimize risk and meet the higher care needs of members awaiting a move out of the ALC, if reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage Case Manager, giving the member 30 days notice of the ALC's intent to terminate the residency agreement and move the member to a more appropriate care provider. The 30 day requirement shall not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when termination of the residency agreement is necessary for the physical safety of the member or other residents of the ALC. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

(I) a full explanation of the reasons for the termination of residency;

(II) the date of the notice;

(III) the date notice was given to the member and the member's representative;

(IV) the date by which the member must leave the ALC; and

(V) notification of appeal rights and process for submitting appeal of termination of Medicaid Assisted Living services to the OHCA.

(D) ADvantage Assisted Living Services provider standards in addition to licensure standards.

(i) Physical environment

(I) The ALC must provide lockable doors on the entry door of each unit and a lockable compartment within each member unit for valuables. Member residents must have exclusive rights to their units with lockable doors at the entrance of their individual and/or shared unit except in the case of documented contraindication. Units may be shared only if a request to do so is initiated by the member resident.

(II) The ALC must provide each unit with a means for each member resident to control the temperature in the individual living unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the resident and that preserves

resident privacy, independence and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(III) For ALCS built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 360 square feet.

(IV) The ALC shall provide a private bathroom for each living unit which must be equipped with one lavatory, one toilet, and one bathtub or shower stall.

(V) The ALC must provide at a minimum a kitchenette, defined as a space containing a refrigerator, cooking appliance (microwave is acceptable), and adequate storage space for utensils.

(VI) The member is responsible for furnishing their rental unit. If a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can and lamp, or if the member supplied furnishings pose a health or safety risk, the member's Case Manager in coordination with the ALC must assist the member in obtaining basic furnishings for the unit.

(VII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, the state and local sanitary codes, state building and fire safety codes and laws and regulations governing use and access by persons with disabilities.

(VIII) The ALC must ensure the design of common areas accommodates the special needs of their resident population and that the residential unit accommodates the special needs of the individual in compliance with ADA Accessibility Guidelines (28 CFR Part 36 Appendix A).

(IX) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(X) The ALC must provide appropriately monitored outdoor space for resident use.

(ii) Sanitation

(I) The ALC must maintain the facility, including its individual units, that is clean, safe, sanitary, insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair and in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member units that maintains a safe, clean and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) Health and Safety

(I) The ALC must provide building security that protects residents from intruders with security measures appropriate to building design, environment risk factors and the resident population.

(II) The ALC must respond immediately and appropriately to missing residents, accidents, medical emergencies or deaths.

(III) The ALC must have a plan in place to prevent, contain and report any diseases that are considered to be infectious and/or are listed as diseases that must be reported to the Oklahoma State Department of Health.

(IV) The ALC must adopt policies for prevention of abuse, neglect and exploitation that include screening, training, prevention, investigation, protection during investigation and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of resident to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure that staff are trained to respond appropriately to emergencies.

(VII) The ALC staff must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for residents.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals;

(X) The ALC must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social/recreational outings.

(iv) Staff to resident ratios

(I) The ALC must ensure that a sufficient number of trained staff be on duty, awake, and present at all times, 24 hours a day, seven days a week, to meet the needs of residents and to carry out all the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other natural disasters.

(II) The ALC must ensure that staffing is sufficient to meet the needs of the ADvantage Program residents in accordance with each individual's ADvantage Service Plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) Staff training and qualifications

(I) The ALC must ensure that all staff have qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by the Oklahoma Department of Health;

(III) The ALC must provide staff orientation and ongoing training to develop and maintain the knowledge and skills of staff. All direct care and activity staff receive at least eight hours of orientation and initial training within the first month of their employment and at least four hours annually thereafter. Staff providing direct care on a dementia unit must receive four additional hours of dementia specific training. Annual first aid and CPR certification do not count towards the four hours of annual training.

(vi) Staff supervision

(I) The ALC must ensure delegation of tasks to non-licensed staff must be consistent and in compliance with all applicable State regulations including, but not limited to, the Oklahoma Nurse Practice Act and the OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors the member's health and nutritional status.

(vii) Resident rights

(I) The ALC must provide to each member and member's representative, at the time of admission, a copy of the resident statutory rights listed in O.S. 63-1-1918

amended to include additional rights and clarification of rights as listed in the ADvantage Consumer Assurances. A copy of the resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that its staff is familiar with, and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees and visitors, the assisted living center's complaint procedures and the name, address and telephone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each resident, the resident's representative, or where appropriate, the court appointed guardian. The ALC must ensure that all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance/appeal rights including a description of the process for submitting a grievance/appeal of any decision that decreases Medicaid services to the member.

(viii) Incident reporting

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage Case Manager, to the ADvantage Program AA and to other entities as required by law or regulation.

(II) Incidents requiring report by licensed Assisted Living Centers are those defined by the Oklahoma State Department of Health (OSDH) in OAC 310:663-19-1.

(III) Reports of incidents must be made to the member's ADvantage Case Manager via facsimile or by telephone within one business day of the reportable incident's discovery. A follow-up report of the incident must be submitted via facsimile or mail to the member's ADvantage Case Manager within five business days after the incident. The final report must be filed with the member's ADvantage Case Manager and to the ADvantage Administration when the full investigation is complete not to exceed ten business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either the Oklahoma Department of Human Services, the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred or

the local municipal police department or sheriff's department as soon as the person is aware of the situation, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes. Reports should also be made to the OSDH, as appropriate, in accordance with the ALC's licensure rules.

(V) The preliminary incident report must at the minimum include who, what, when and where and the measures taken to protect the resident(s) during the investigation. The follow-up report must at the minimum include preliminary information, the extent of the injury or damage, if any, and preliminary findings of the investigation. The final report at the minimum includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings; and corrective measures to prevent future occurrences. If necessary to omit items, the final report must include why items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services

(I) The ALC must arrange or coordinate transportation for members to and from medical appointments.

(II) The ALC must provide or coordinate with the member and the member's ADvantage Case Manager for delivery of necessary health services. The ADvantage Case Manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the service plan are provided in an appropriate and timely manner.

(E) Assisted Living Services are billed per diem of service for days covered by the ADvantage member's service plan and during which the Assisted Living Services provider is responsible for providing Assisted Living serviced as needed by the member. The per diem rate for the ADvantage assisted living services for a member will be one of three per diem rate levels based upon individual member's need for service - type intensity and frequency to address member ADL/IADL and health care needs. The rate level is based upon UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to QMBP, SLMB, and other Medicaid services eligibility

(a) Long-term medical care for the categorically needy includes:

(1) care in a nursing facility (refer to OAC 317:35-19);

(2) care in a public or private intermediate care facility for the mentally retarded (refer to OAC 317:35-9);

(3) care of persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9);

(4) Home and Community Based Services Waivers for the Mentally Retarded persons with (refer to OAC 317:35-9);

(5) Personal Care services (refer to OAC 317:35-15); and

(6) the Home and Community Based Services Waiver for frail elderly, and a targeted group of adults with physical disabilities age 21 and over who do not have mental retardation or a cognitive impairment (ADvantage Waiver).

(b) Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. ADvantage Waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage Assisted Living Center, any income beyond 150% of the federal benefit rate is available to defray the cost of the Assisted Living services received. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each full month in which services have been received until the vendor pay obligation is met. Any time an individual is aged, blind or disabled ~~individual~~ and is determined eligible for long-term care, a separate eligibility determination must be made for Qualified Medicare Beneficiary Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) benefits. An ADvantage program member may reside in a licensed assisted living facility only if the assisted living center is a certified ADvantage Assisted Living Services provider from whom the member is receiving ADvantage Assisted Living services.

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

The OKDHS area nurse, or nurse designee, determines medical eligibility for ADvantage program services based on the ~~Long Term Care (LTC) nurse's~~ Uniform Comprehensive Assessment Tool (UCAT) III assessment and the determination that the ~~client~~ member has unmet care needs that require ADvantage or NF services to assure ~~client~~ member health and safety. ADvantage services are initiated to support the informal care that is being provided in the ~~client's~~ member's home, or, that based on the UCAT, can be expected to be provided in the ~~client's~~ members's home upon discharge of the

~~client~~ 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 ~~provided by family members and/or by significant others~~. 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 ~~client's~~ 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 ~~client's~~ member's total weighted UCAT ADL score is 10 or more which indicates the ~~client~~ member needs some help with 5 ADLs or that the ~~client~~ member cannot do 3 ADLs at all plus the ~~client~~ member needs some help with 1 other ADL.

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

~~(D) **"CHC"** means Comprehensive Home Care.~~

~~(E)~~ (D) **"Client Support high risk"** means ~~client's~~ 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 ~~client~~ 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 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 ~~client's~~ 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 ~~client~~ 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 ~~person~~ individual, as determined by the clinical judgment of the ~~LTC~~ 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 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 ~~person~~ 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 ~~client's~~ 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.

~~(J)~~ (K) **"Environment moderate risk"** means ~~client's~~ 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.

~~(K)~~ (L) **"Health Assessment high risk"** means ~~client's~~ member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the ~~client~~ member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and

requiring 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.

~~(L)~~ (M) **"Health Assessment low risk"** means ~~client's~~ member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the ~~client~~ 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.

~~(M)~~ (N) **"Health Assessment moderate risk"** means ~~client's~~ member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the ~~client~~ 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.

~~(N)~~ (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.

~~(O)~~ (P) **"IADLs score in high risk range"** means ~~client's~~ member's total weighted UCAT IADL score is 12 or more which indicates the ~~client~~ member needs some help with 6 IADLs or cannot do 4 IADLs at all.

~~(P) **"Instrumental activities of daily living"** means those activities that reflect the client's ability to perform 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.~~

(Q) **"Mental Retardation"** means that the ~~person~~ 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 ~~client's~~ 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 ~~client's~~ 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 ~~client~~ 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 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.

~~(W)~~ (Z) **"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the ~~client~~ 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) ~~Client~~ 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) ~~of absence of support are met~~ Loss of independence;

(C) Expanded criteria: The UCAT documents that:

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

(ii) the ~~client~~ 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; and

~~(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.~~

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance ~~noninstitutional~~ non-institutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ~~ADvantage program members must be SoonerCare eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage Assisted Living Center.~~ Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Mediciad eligibility. Eligibility for ADvantage is contingent on an individual requiring one or more of the services offered in the waiver at least monthly in order to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if age 21 or older and not physically disabled, the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have mental retardation or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet the following criteria:

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria ~~[see OAC 317:35-17-3(d) OAC]~~ [see OAC 317:35-17-3(f)]; and

(C) meet program eligibility criteria ~~[see OAC 317:35-17-3(e)]~~ [see OAC 317:35-17-3(g)].

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth below.

(1) ADvantage program members are not eligible to receive services while residing in an institutional setting, including but not limited to licensed facilities such as a hospital, a nursing facility, a licensed residential care facility, or a licensed assisted living facility, (unless the facility is an ADvantage Assisted Living Center), or in an unlicensed institutional living arrangement such as a room and board home/facility.

(2) ADvantage program members may receive services in a contracted ADvantage Assisted Living Center; an ADvantage Assisted Living Center is the only housing-with-nursing-supervised personal care services option in which a person may appropriately receive ADvantage services.

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

(4) ADvantage program members may receive services in a shelter or similar temporary housing arrangement which may or may not meet the definition of home/apartment, in emergency situations, for a period not to exceed sixty (60) days during which location and transition to permanent housing is being sought.

(5) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services for the period during which the member is a student.

(6) Members may receive ADvantage respite services in a nursing facility for a continuous period not to exceed thirty (30) days.

~~(b)~~ (d) Home and Community Based Waiver Services are outside the scope of Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap.

~~(c)~~ (e) Services provided through the ADvantage waiver are:

(1) case management;
(2) respite;
(3) adult day health care;
(4) environmental modifications;
(5) specialized medical equipment and supplies;
(6) physical therapy/occupational therapy/speech therapy or consultation;
(7) advanced supportive/restorative assistance;
(8) ~~skilled~~ nursing;
(9) home delivered meals;
(10) hospice care;
(11) medically necessary prescription drugs within the limits of the waiver;
(12) personal care (state plan) or ADvantage personal care;
(13) Personal Emergency Response System (PERS);
(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
(15) Institution Transition Services;
(16) assisted living; and
(17) SoonerCare medical services for individuals age 21 and over

within the scope of the State Plan.

~~(d)~~ (f) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the individual. If the OKDHS/ASD determines all ADvantage waiver slots are filled, the individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the individual's name is placed on a waiting list for entry as an open slot becomes available. ~~ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for persons that have a developmental disability and those that do not have a developmental disability.~~

(2) the individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have mental retardation or a cognitive impairment.

(3) the individual ~~does not pose~~ is not eligible if he/she poses a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(5) the individual is not eligible if his/her living environment poses a physical threat to self or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the person to move are unsuccessful or not feasible.

~~(e)~~ (g) The State, as part of the waiver program approval authorization, assures CMS that each member's health, safety or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured. The ~~OKDHS/ASD~~ AA determines ADvantage program eligibility through the service plan approval process. ~~The following criteria are used to make the ADvantage program eligibility determination that an individual is not eligible:~~ An individual is deemed ineligible for the ADvantage program based on the following criteria:

(1) ~~if~~ the individual's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver individual's health, safety, or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) ~~if~~ the individual poses a physical threat to self or others as supported by professional documentation.

(3) ~~if~~ other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

~~(4) if the individual's needs are being met, or do not require ADvantage services to be met, or if the individual would not require institutionalization if needs are not met.~~

~~(5)~~ (4) ~~if,~~ after the service and care plan is developed, the risk to individual's health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OKDHS/ASD.

(5) the individual's living environment poses a physical threat to self or others as supported by professional documentation, where applicable and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) the individual's health safety or welfare in their home cannot be assured due to continued refusal of planned services.

(7) the individual does not require at least one ADvantage service monthly.

~~(f)~~ (h) The case manager provides the ~~OKDHS/ASD~~ AA with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the OKDHS/ASD will provide technical assistance to the Provider for transitioning the individual to other services.

~~(g)~~ (i) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

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 for 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) An individual residing in an NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when Medicaid application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid long-term care eligibility is made.~~

~~(3)~~ (2) When Medicaid application is being made, an assessment of resources must be completed ~~if it was not completed when the individual entered the NF or began receiving waiver services~~. For applicants of the ADvantage waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. ~~If the individual applies for Medicaid at the time of entry into the ADvantage waiver, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the Medicaid application form and computed using OKDHS form MA-12, Title XIX Worksheet.~~

(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 ~~client's~~ applicant's county of residence for Medicaid eligibility determination. The application date is the date the ~~client~~ applicant signed the application form for the provider.

(c) **ADvantage waiting list procedures.** ADvantage Program "available capacity" is the number of ~~clients~~ 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) 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 OKDHS area nurse, or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) I, Part III, and other available medical information.

(1) When ADvantage care services are requested or the UCAT is received in the county office:

(A) the ~~LTC~~ OKDHS nurse is responsible for completing the UCAT III.

(B) the social worker is responsible for contacting the individual within three working days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. If categorical relationship to disability has not already been established, the local social worker submits the same information described in OAC 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship to the disabled using the same definition used by SSA. A follow-up is required by the

OKDHS social worker with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.

(3) Community agencies complete the UCAT, Part I and forwards the form to the county office. If the UCAT, Part I indicates that the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources.

(4) The ~~LTC~~ OKDHS nurse completes the UCAT, Part III assessment visit with the ~~client~~ member within 10 working days of receipt of the referral for ADvantage services for a client who is Medicaid eligible at the time of the request. The ~~LTC~~ OKDHS nurse completes the UCAT, Part III assessment within 20 working days of the date the Medicaid application is completed for new ~~clients~~ applicants.

(5) During the assessment visit, the ~~LTC~~ OKDHS nurse informs the ~~client~~ applicant of medical eligibility and provides information about the different long-term care service options. If there are multiple household members applying for the ADvantage program, the UCAT assessment is done for the applicant household members during the same visit. The ~~LTC~~ OKDHS nurse documents whether the ~~client~~ member chooses NF program services or ADvantage program services. In addition, the LTC nurse makes a level of care and service program recommendation.

(6) The ~~LTC~~ OKDHS nurse informs the ~~client~~ member and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the client's primary and secondary informed choices.

(A) If the ~~client~~ member and/or family declines to make a provider choice, the ~~LTC~~ OKDHS nurse documents that decision on the ~~client~~ member choice form.

(B) The AA uses a rotating system to select an agency for the ~~client~~ member from a list of all local certified case management and in-home care agencies.

(7) The ~~LTC~~ OKDHS nurse documents the names of the chosen agencies and the agreement (by dated signature) of the ~~client~~ member to receive services provided by the agencies.

(8) If the needs of the ~~client~~ member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the ~~LTC~~ OKDHS nurse documents the need for priority processing.

(9) The ~~LTC~~ OKDHS nurse scores the UCAT, Part III. The ~~LTC~~ OKDHS nurse forwards the UCAT, Parts I and III, documentation of financial eligibility, and documentation of the ~~client's~~ member's case management and in-home care agency choices to the area nurse, or nurse designee, for medical eligibility determination.

(10) If, based upon the information obtained during the assessment, the ~~LTC~~ OKDHS nurse determines that the ~~client~~ member may be at risk for health and safety, OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.
(11) Within ten working days of receipt of a complete ADvantage application, the area nurse, or nurse designee, determines medical eligibility using NF level of care criteria and service eligibility criteria [refer to OAC 317:35-17-2 and OAC 317:35-17-3] and enters the medical decision on the system. ~~The original documents are sent with the MS-52 to the AA.~~
(12) Upon notification of financial eligibility from the social worker, medical eligibility (MS-52) and approval for ADvantage entry from the area nurse, or nurse designee, the AA communicates with the ~~client and~~ case management provider to begin care plan and service plan development. The AA communicates to the client's case management provider the ~~client's~~ member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development~~, whether the needs of the client require an immediate IDT meeting with home health agency nurse participation and the effective date for client entry into ADvantage~~. If the member requires an immediate home visit to develop a service plan within 24 hours, the AA contacts the case management provider directly to confirm availability and then sends the new case packet information to the case management provider via facsimile.
(13) If the services must be in place to ensure the health and safety of the ~~client~~ member upon discharge to the home from the NF or Hospital, ~~the AA provides administrative case management to develop and implement the care plan and service plan. For administrative case management, the AA, or~~ a nurse case manager from an ADvantage case management provider selected by the client and referred by the AA follows ADvantage Institution Transition case management procedures for care plan and service plan development and implementation. ~~If the AA has provided transition case management services, when the client returns home, the AA begins transitioning case management to the ADvantage case management provider chosen by the client.~~
~~(14) If a client in a hospital requests ADvantage services, the hospital initiates a request for Medicaid ADvantage services by contacting the AA for intake and screening.~~
~~(A) The AA, or a nurse case manager from an ADvantage case management provider selected by the client and referred by the AA completes the UCAT, Part III assessment visit, if possible, with the hospitalized applicant. If the local~~

~~OKDHS office receives the request for Medicaid ADvantage services for a client in a hospital it is referred to the AA. During the assessment visit, the AA, or ADvantage nurse case manager informs the client of financial and medical eligibility criteria and provides information about the different long-term care service options. The AA, or ADvantage nurse case manager documents the client's choice on the UCAT, Part III. The AA, or ADvantage nurse case manager will review forms documenting the selection of provider(s), agreement with the service plan and release of information with the client and obtain the client's dated signature on the forms.~~

~~(B) If the UCAT indicates the client is eligible for ADvantage services and financial eligibility has been determined, the AA, or ADvantage nurse case manager, in consultation with the hospital discharge planner provides administrative case management. The AA, or ADvantage nurse case manager develops a temporary care plan and service plan if services must be in place to ensure the health and safety of the client upon discharge from the hospital. When the client returns home, the AA, or ADvantage nurse case manager transitions case management to the ADvantage case management provider chosen by the client.~~

~~(C) The completed assessment forms are submitted to the OKDHS area nurse who makes the medical eligibility decision, enters it on the system and notifies the AA of the decision.~~

~~(D) If the applicant is determined not eligible for ADvantage, providers follow special procedures specified by the AA to bill for services provided. If authorized by the AA, case management providers may bill using an administrative case management procedure code for services delivered and not reimbursable under any other ADvantage case management procedure code.~~

~~(15)~~ (14) ~~If the client has a current certification and requests a change from Personal Care Services to ADvantage services, a new UCAT is required. The UCAT is updated when a client requests a change from ADvantage services to Personal Care services, or when a client requests a change from the nursing facility to ADvantage services. If a client is receiving ADvantage services and requests to go to a nursing facility, a new medical level of care decision is not needed.~~ A new medical level of care determination is required when a member requests any of the following changes in service program:

(A) from State Plan Personal Care to ADvantage services.

(B) from ADvantage to State Plan Personal Care services.

(C) from Nursing Facility to ADvantage services.

(D) from ADvantage to Nursing Facility services.

(15) A new medical level of care determination is not required when a member requests re-activation of ADvantage services after a short-term stay (90 days or less) in a Nursing Facility when the member has had previous ADvantage services and the ADvantage certification period has not expired.

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

317:35-17-11. Determining financial eligibility for ADvantage program services

Financial eligibility for individuals in ADvantage program services is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services

Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of ADvantage program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in the ADvantage or HCBW/MR program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of ADvantage services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the

individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in the ADvantage or HCBW/MR program.** When only one individual of a couple in their own home is in the ADvantage or HCBW/MR program, income and resources are determined separately. However, the income and resources of the individual who is not in the ADvantage or HCBW/MR program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in ADvantage program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the ADvantage program services cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the ADvantage program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving ADvantage program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. ~~When application for SoonerCare is made at the same time the individual begins receiving ADvantage program services, OKDHS Form 08MA012E, Title XIX Worksheet, is used.~~

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the ADvantage program services (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form

08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving ADvantage program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving ADvantage program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the ADvantage program service, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a

determination of:

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving ADvantage program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Vendor payment.** For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, after allowable deeming to the community spouse, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

317:35-17-12. Certification for ADvantage program services

(a) **Application date.** If the applicant is found eligible for SoonerCare, certification may be effective the date of application. The first month of the certification period must be the first month the member was determined eligible for ADvantage, both financially and medically.

(1) As soon as eligibility or ineligibility for ADvantage program services is established, the worker updates the computer form and the appropriate notice is computer generated to the member and the ADvantage Administration (AA). Notice

information is retained on the notice file for county use.

(2) An applicant approved for ADvantage program services is mailed a Medical Identification Card.

(b) **Financial certification period for ADvantage program services.** The financial certification period for the ADvantage program services is 12 months. Although "medical eligibility number of months" on the computer input record will show 99 months, redetermination of eligibility is completed according to the categorical relationship.

(c) **Medical Certification period for ADvantage program services.** The medical certification period for ~~the~~ ADvantage program services is up to 12 months. ~~Reassessment and redetermination~~ Redetermination of medical eligibility is completed by OKDHS in coordination with the annual ~~recertification~~ reauthorization of the member's service plan ~~by the case manager~~. ~~In addition, an~~ An independent ~~evaluation~~ redetermination of medical eligibility is completed by the OKDHS Nurse ~~at least every third year~~ when, depending upon the needs of the member, the medical certification is determined to be less than 12 months, or, at any time~~. If~~ documentation supports a reasonable expectation that the member ~~will~~ may not continue to meet medical eligibility criteria ~~or have a need for long term care services for more than 12 months, the OKDHS Nurse does an independent evaluation of medical eligibility before the end of the current medical certification period~~.

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 working day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. ~~Within three working days of being assigned an ADvantage member, the~~ The case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, ~~AA~~ and OKDHS in the program), ~~and~~ review, update and complete the UCAT assessment, ~~and to~~ discuss service needs and ADvantage service providers. The Case Manager notifies in writing the member's UCAT identified primary physician that the member has been determined eligible to receive ADvantage services. The notification is via 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.

(2) Within 14 calendar days of the receipt of an ADvantage referral, the case manager completes and submits to the AA an

individualized care plan and service plan for the member, signed by the member and the case management supervisor. The case manager completes and submits to the AA the annual reassessment service plan documents no sooner than 60 days before the existing service plan end date but sufficiently in advance of the end date to be received by the AA at least 30 calendar days before the end date of the existing service plan. Within 14 calendar days of receipt of a Service Plan Review Request (SPR) from the AA, the Case Manager provides corrected care plan and service plan documentation. Within five calendar days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the care plan and service plan. The care plan and service plan are based on the member's service needs identified by the UCAT, Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for care plan and service plan development. If in-home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage in-home care provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ADvantage case manager documents on the care plan the presence of two 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 IVRA system in the member record any instance in which a member's health or safety would be "at risk" if even one 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 with the care plan and service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the member signs with a mark. If the member refuses to cooperate in development of the service plan, or, if the member refuses to sign the service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the ~~LTC~~ OKDHS nurse or AA may identify members that require AA intervention.

(A) For members that are uncooperative or disruptive, the ~~AA~~

case manager develops an individualized ~~Addendum to the Rights and Responsibilities Agreement~~ plan to overcome challenges to receiving services ~~to try to modify the member's uncooperative/disruptive behavior. The Rights and Responsibilities addendum focuses~~ focusing on behaviors, both favorable and those that jeopardize the member's well-being and includes a design approach of incremental plans and addenda that allow the member to achieve stepwise successes in the modification of their behavior.

(B) The AA may implement a service plan without the member's signature ~~if the AA has developed an Addendum to the Rights and Responsibilities Agreement for the member. For~~ when, for these members, the presence of a document that "requires" their signature may itself trigger a "conflict". In these circumstances, mental health/behavioral issues may prevent the member from controlling their behavior to act in their own interest. Since the person by virtue of level of care and the IDT assessment, needs ADvantage services to assure their health and safety, the AA may ~~implement~~ authorize the service plan if the ~~AA~~ case manager demonstrates effort to work with and obtain the member's agreement ~~through an individualized Addendum to the Rights and Responsibilities Agreement~~. Should negotiations not result in agreement with the care plan and service plan, the member may withdraw their request for services or request a fair hearing.

(4) CD-PASS Planning and Supports Coordination.

(A) The ADvantage Case Management provider assigns to the CD-PASS member a Case Manager that has successfully completed training on CD-PASS, Independent Living Philosophy, ~~and~~ Person-Centered Planning and the individual budgeting process and process guidelines. Case Managers that have completed this specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to their CD-PASS service planning and support role in working with CD-PASS members. The CDA/CM educates the member about their rights and responsibilities as well as about community resources, service choices and options available to the member to meet CD-PASS service goals and objectives.

(B) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If 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 the 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 Personal Services Assistance 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 this is included in the reassessment packet to AA.

(C) The CDA/CM provides support to the member in the Person-Centered CD-PASS Planning process. ~~Person-Centered Planning is a process directed by the participant, with assistance as needed from an "authorized representative" or support team. The process supports the member to exercise choice and control and to assume a responsible role in developing, implementing and managing their services and supports. The process is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant and it may enlist assistance from individuals freely chosen by the participant to serve as important contributors. The Person-Centered Planning process enables the participant to identify and access a personalized mix of paid and non-paid services and supports to help him/her achieve personally-defined outcomes in the most inclusive community setting. The focus of Person-Centered Planning is on the individual's development of personal relationships, positive roles in community activities, and self-empowerment skills. Decisions are made and outcomes controlled by the participant. Strengths, preferences and an individualized system of support are identified to assist the individual to achieve functional and meaningful goals and objectives.~~ Principles of Person-Centered Planning are as follows:

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

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

(iv) The individual 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.

(D) The CDA/CM encourages and supports the member, or as

applicable their designated "authorized representative", to lead, to the extent feasible, the CD-PASS service planning process for Personal Services Assistance. The CDA/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 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 assists the member in translating the assessment of member needs and preferences into an individually tailored, personalized service plan.

(E) To the extent the member prefers, the CDA/CM develops assistance to meet member needs using a combination of traditional Personal Care and CD-PASS PSA services. However, the CD-PASS IBA and the PSA unit authorization will be reduced proportional to agency Personal Care service utilization.

(F) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the service plan. The start date must be after authorization of services, after completion and approval of the background checks and after completion of the member employee packets.

(G) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage service plan or plan amendment to authorize CD-PASS Personal Service Assistance units consistent with this individual plan and notifies existing duplicative Personal Care service providers of the end date for those services.

(H) If the plan requires an APSA to provide assistance with Health Maintenance activities, the CDA/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;

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

(ii) If the member and APSA attest that the APSA has been 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 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.

(I) The CDA/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. If 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, based upon an updated assessment, amends the service plan to ~~increase~~ modify CD-PASS service units appropriate to meet additional member's need and forwards the plan amendment to the AA for authorization and update of the member's IBA.

(J) The CDA/CM uses the ADvantage Risk Management process the results of which are binding on all parties to resolve service planning or service delivery disagreements between members and ADvantage service providers under the following circumstances:

(i) A claim is formally registered with the CDA/CM by the member (or the member's family or "authorized representative"), the AA, or a provider that the disagreement poses a significant risk to the member's health or safety; and

(ii) The disagreement is about a service, or about the appropriate frequency, duration or other aspect of the service; or

(iii) The disagreement is about a behavior/action of the member, or about a behavior/action of the provider.

(K) The CDA/CM and the member prepare an emergency backup/emergency response capability for CD-PASS PSA services in the event a PSA provider of services essential to the individual's health and welfare fails to deliver services. As part of the planning process, the CDA/CM and member define what failure of service or neglect of service tasks would constitute a risk to health and welfare to trigger implementation of the emergency backup. Any of the following may be used in planning for the backup:

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

(ii) Identification of one or more qualified substitute ADvantage agency service providers (Adult Day Care, Personal Care or Nursing Facility Respite provider) and preparation for their quick response to provide backup services when called upon in emergency circumstances.

(L) If the emergency backup fails, the CDA/CM is to request the AA to authorize and facilitate member access to Adult Day Care, Agency Personal Care or Nursing Facility Respite services.

(5) The case manager submits the care plan and service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within two working days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected care plan and service plan to the case management supervisor within two working days. The case management supervisor returns the approved care plan and service plan to the case manager. Within one working day of receiving supervisory approval, the case manager forwards, via postal mail, a legible copy of the care plan and service plan to the AA. Case managers are responsible for retaining all original documents for the member's file at the agency. Only priority service needs and supporting documentation may be faxed to the AA with the word, "PRIORITY" being clearly indicated and the 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 nursing facility. Corrections to service conditions set by the AA are not considered to be 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 nursing facility.

(6) Within one working day of notification of care plan and service plan authorization, the case manager communicates with the service plan providers and with the member to facilitate service plan implementation. Within one working day of receipt of a copy or the computer-generated authorized service plan from the AA, the case manager sends (by mail or fax) copies of the authorized service plan or computer-generated copies to providers. Within five working days of notification of an initial service plan or a new reassessment service plan authorization, the case manager visits the member, gives the member a copy of the service plan or computer-generated copy of the service plan and evaluates the progress of the service plan implementation. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and

(B) monthly after the initial 30 day follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans.**

The ADvantage Administration (AA) ~~certifies~~ authorizes the individual service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, plan cost effectiveness, that service providers 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. ~~Except as provided by the process described in 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 (spouse or parent of a minor child).~~

(1) Except as provided by the process described in 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 (spouse or parent of a minor child).

(2) The OKDHS/ASD may under criteria described in 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 PCA's.

~~(1)~~ (3) If the service plan authorization or amendment request packet received from case management is complete and the service plan is within cost effectiveness guidelines, the AA authorizes or denies authorization within five working days of receipt of the request. If the service plan ~~authorization or amendment request packet received from case management is complete and 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. If the request packet is not complete, the AA notifies the case manager immediately and puts a "hold" on authorization until the required additional documents are received from case management.

~~(2)~~ (4) The AA authorizes the service plan by entering the authorization date and ~~signing the submitted service plan~~ assigning a control number that internally identifies the OKDHS staff completing the authorization. Notice of authorization and a computer-generated copy of the authorized plan or a computer-generated copy of the authorized plan are provided to case management. AA authorization determinations are provided to case management within one working day of the ~~certification~~ authorization date. A 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 5 working days. ~~(3)~~ (5) For audit purposes (including ~~SURS~~ Program Integrity reviews), the computer-generated copy of the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. State or Federal quality review and audit officials may obtain a copy of specific service plans with original signatures by submitting a request to the ~~AA~~ member's case manager.

(c) **Change in service plan.** The process for initiating a change in the 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 service plan. The requested changes and justification for them are documented by the service provider and, if initiated by a direct care provider, submitted to the member's case manager. If in agreement, the case manager requests the service changes on a care plan and service plan amendment submitted to the AA within five calendar days of assessed need. The AA ~~approves~~ authorizes or denies the care plan and service plan changes ~~within five calendar days of receipt of the plan~~ per 317:35-17-14.

(2) The member initiates the process for replacing Personal Care services with Consumer-Directed Personal Services and Supports (CD-PASS) in geographic areas in which CD-PASS services are available. The member may contact the AA ~~using a CD-PASS services request form provided by the Case Manager~~ or by calling the toll-free number established to process requests for CD-PASS 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 or more adjustment in services per week, requires ~~a~~ an updated UCAT reassessment by the case manager. The case manager~~, in consultation with AA, makes the determination of need for reassessment. Develops~~ develops an amended or new service plan and care plan, as appropriate, and submits the new amended plans for authorization.

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

(A) the presence of two 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 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 service plan or be eligible for a different service program. If 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. If unable to obtain the member's consent for voluntary closure, the case manager requests assistance from the AA. The AA requests that the OKDHS area nurse initiate a reconsideration of level of care. ~~If the member's service needs are different or have significantly increased, the case manager develops an amended or new service plan and care plan, as appropriate, and submits the new/amended plans for authorization.~~

317:35-17-15. Redetermination of eligibility for ADvantage services
(a) The worker must complete a redetermination of financial eligibility prior to the end of the certification period. A notice is generated only if there is a change which affects the member's financial responsibility.
(b) The ADvantage case manager or the OKDHS nurse must complete ~~a~~ an annual UCAT reassessment that is reviewed for redetermination of medical eligibility prior to the end of the certification period.

317:35-17-16. Member annual level of care re-evaluation and annual re-authorization of service plan
(a) Annually, the case manager reassesses the member's needs using the UCAT Part I, III and then evaluates the current service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan to the AA for authorization. The case manager initiates the UCAT reassessment and development of the new service plan at least 40 days, but not more than ~~55~~ 60 days, prior to the current service plan authorization end date. The case manager provides the AA the new reassessment service plan packet no less than 30 days prior to the end date of the existing plan. The new reassessment service plan packet includes the reassessed service plan, UCAT Parts I and III, Nurse Evaluation and any supporting documentation.
(b) OKDHS reviews the ADvantage case manager UCAT for a level of care redetermination. If policy defined criteria for Nursing Facility level of care cannot be determined or cannot be justified from documentation available or via direct contact with the case manager, a UCAT is completed in the home by the local OKDHS nurse. The local OKDHS nurse submits the UCAT evaluation to the area nurse, or nurse designee, to make the medical eligibility level of care determination.

(c) If medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until level of care redetermination is established. If the member no longer meets medical eligibility the area nurse, or nurse designee, updates the system=s "medical eligibility end date" and simultaneously notifies AA electronically.
(d) If OKDHS determines a member no longer meets medical eligibility, the AA communicates to the member=s case manager that the member has been determined to no longer meet medical eligibility for ADvantage as of the effective date of the eligibility determination. The case manager communicates with the member and if requested, assists the member to access other services.

317:35-17-17. Supplemental process for expedited eligibility determination (SPEED) [REVOKED]

~~(a) When the ADvantage Administration (AA) determines that a person requires ADvantage services to begin immediately to prevent nursing facility admission or to ensure the person's health or safety and the UCAT, Part I documents that the person is expected to be eligible for ADvantage, either the OKDHS nurse or the AA will complete the assessment for medical eligibility determination. The completed assessment forms are submitted to the area nurse who makes the medical eligibility decision, enters it on the system and notifies the AA of the decision.~~

~~(b) If the applicant fails to meet financial eligibility, providers follow special procedures specified by the AA to bill for services provided. If authorized by the AA, case management providers may bill using an administrative case management procedure code for SPEED services delivered and not reimbursable under any other ADvantage case management procedure code.~~

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

When the member's OKDHS social worker, ADvantage case manager, or the AA is informed (by the member, family or service provider) of a member's hospitalization or placement in a nursing facility, 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. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the 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 if provided while the person is in an institution, are to be considered delivered on and billed for the date the member returns home from institutional care. ~~When the case manager is informed (by the member, family or service provider) of a member's hospitalization or placement in an NF, the case manager determines the date of the member's institutionalization and communicates the date, name of institution, reason for placement and expected duration of placement to the ADvantage Administration (AA) and the member's OKDHS worker.~~

(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 AA and coordinates the resumption of services.

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

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the member's 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. In these circumstances, the SPEED process may be used to re-establish ADvantage eligibility to coincide with the date of discharge from the NF. The member's case manager provides "institution transition" case management services to assist the member to re-establish him or herself safely in the home.

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

(a) **Voluntary closure of ADvantage services.** If the ~~client~~ member requests a lower level of care than ADvantage services or if the ~~client~~ member agrees that ADvantage services are no longer needed to meet his/her needs, a medical decision by the area nurse, or nurse designee, is not needed. The closure request is completed and signed by the ~~client~~ member and the case manager and sent to the AA to be placed in the ~~client's~~ member's case record. The AA notifies the OKDHS county office of the voluntary closure and effective date of closure. The case manager documents in the case record all circumstances involving the reasons for the voluntary

termination of services and alternatives for services if written request for closure cannot be secured.

(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.** Anytime the local OKDHS office determines a ~~client~~ member does not meet the financial eligibility criteria, the local OKDHS office notifies the ~~client~~, member provider, and AA of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** Any time the local OKDHS office is notified through MEDATS of a decision that the individual is no longer medically eligible for ADvantage services, the local office notifies the individual, AA and provider of the decision.

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

(d) **Resumption of ADvantage services.** If a ~~client~~ member approved for ADvantage services has been without services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a ~~client~~ member decides he/she desires to have his/her services restarted after 90 days, the ~~client~~ member must request the services as a new referral through the county office. If an individual is determined to be eligible for Advantage services and is transitioning from a hospital or a nursing facility to a community setting, an ADvantage case manager may provide Institution Transition case managemet services to assist the individual to establish or re-establish him or herself safely in the home.

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

~~Either Aging Services or the~~ ADvantage Administration (AA) forwards information on all certified ADvantage and Personal Care agency providers providing services in the specific OKDHS area to the area nurse and OKDHS county director. The provider information includes agency name, address, contact person for ADvantage/Personal Care programs, provider number, a list of ADvantage/Personal Care 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 additional providers are certified in an OKDHS area or if a provider loses certification, ~~Aging Services or the~~ AA provides appropriate notice to the area nurse and OKDHS county director in counties affected by the certification changes. The 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.

317:35-17-24. Referral for social services

In many situations, social services are needed by adults who are receiving medical services through Medicaid. The ~~LTC~~ OKDHS nurse may make referrals for social services to the social worker in the local office. In addition to these referrals, a request for social services may be initiated by a ~~client~~ member or by another individual acting upon behalf of a ~~client~~ member.

(1) The social worker is responsible for providing the indicated services or for referral to the appropriate resource outside the Department if the services are not available within the Department.

(2) Among the services provided by the social worker are:

(A) Services which will enable individuals to attain and/or maintain as good physical and mental health as possible;

(B) Services to assist patients who are receiving care outside their own homes in planning for and returning to their own homes or to other alternate care;

(C) Services to encourage the development and maintenance of family and community interest and ties;

(D) Services to promote maximum independence in the management of their own affairs;

(E) Protective services, including evaluation of need for and arranging for guardianship; and

(F) Appropriate family planning services which include assisting the family in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.