TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance noninstitutional 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. 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 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)]; and

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

(b) 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. ~~To meet program cost effectiveness eligibility criteria, the annualized cost of a individual's ADvantage services cannot exceed the ADvantage program services expenditure cap unless approved by the Oklahoma DHS Aging Services Division (OKDHS/ASD) in accordance with the exceptions listed in (1)- (5) of this subsection. The cost of the service plan furnished to an individual may exceed the expenditure cap only when all of the increased expenditures above the cap are due solely to:~~

~~(1) a one-time purchase of home modifications and/or specialized medical equipment; and/or~~

~~(2) documented need for a temporary (not to exceed a 60-day limit) increase in frequency of service or number of services to prevent institutionalization; or~~

~~(3) expenditures are for ADvantage Hospice services;~~

~~(4) expenditures in excess of the cap are for prescribed drugs, which would be paid by SoonerCare if the individual were receiving services in a nursing home; and/or~~

~~(5) expenditures are for Institution Transition Services, and the annualized expenditures for ADvantage services to an individual under any combination of circumstances described under exceptions (1) through (5) can reasonably be expected to be no more than 200% of the individual cap.~~

(c) 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/respiratory 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) 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 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.

(e) The OKDHS/ASD 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:

(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) 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.

(f) The case manager provides the OKDHS/ASD 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) 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) 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 county of residence for Medicaid eligibility determination. The application date is the date the client signed the application form for the provider.

(c) **ADvantage waiting list procedures.** ADvantage Program "available capacity ~~in the month~~" is the number of ~~additional~~ clients that may be enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. ~~The available capacity in the month for any particular month is calculated as follows: Available capacity in the month equals [(Waiver year C value) minus (unduplicated number during the current waiver fiscal year served as of the last day of the previous month)] divided by (the number of months remaining in the waiver year). Upon notification from the AA that 102% of the available capacity in the previous month was 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. Up to a maximum of five requests for ADvantage Program services from individuals who have resided in a nursing facility for a minimum of two months and who are transitioning from nursing facility to home-based care under Oklahoma's Real Choice Systems Change Nursing Facility Transition Services Pilot are exempt from waiting list procedures. Upon implementation and for the duration of waiting list procedures, the SPEED policy described under OAC 317:35-17-17 is suspended except for persons identified through the Nursing Facility Transition Services Pilot as being exempt from waiting list procedures.~~

~~(1) Each month as additional waiver slots are available, the AA forwards requests from the waiting list to the appropriate~~

~~OKDHS county office for processing the application.~~
~~(2) The criterion for suspending waiting list procedures is the occurrence of two consecutive months in which no person is retained on the waiting list the entire month and less than 95% of the available capacity in the month is attained. Upon notification from the AA that waiting list procedures are no longer necessary, OKDHS/ASD notifies OKDHS county offices and contract agencies approved to complete the UCAT, Parts I and II to process requests for ADvantage services as applications.~~ 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.

317:35-17-16. 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 ~~the~~ 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 ~~certification~~ authorization. ~~Along with the service plan submitted for annual recertification, the case manager forwards to AA the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.~~
~~(b) At a maximum of every 11 months, the ADvantage case manager makes a home visit to evaluate the ADvantage member using the UCAT, Parts I and III and other information as necessary as part of the annual service plan development process. The OKDHS nurse evaluation substitutes for the case manager's fourth quarter assessment in the client's third year.~~
~~(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.~~
~~(2) As part of the service plan recertification process, the AA~~

~~evaluates whether the member continues to meet policy defined criteria for Nursing Facility level of care.~~
~~(3) Except for enrollment years in which the OKDHS nurse is scheduled to do an independent assessment for medical eligibility, the AA notifies OKDHS/ASD electronically of member medical assessment by providing the member's identifying information and the member's UCAT Part III including level of care criteria domain scores to justify member medical eligibility recertification for an additional 12 month period.~~
~~(4) OKDHS/ASD determines whether a member requires further assessment for annual medical eligibility determination. For a member requiring further assessment, and at least every third year, the OKDHS nurse schedules a home visit with the member to do a UCAT reassessment which will be used for redetermination of medical eligibility.~~
~~(5) The OKDHS nurse submits the UCAT evaluation to the area nurse, or nurse designee, for a determination of continued medical eligibility. The area nurse, or designee, makes the medical eligibility decision and recertifies medical eligibility prior to expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the area nurse, or nurse designee, updates the system's "medical eligibility end date" and notifies the AA electronically. 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, helps the member to arrange alternate services in place of ADvantage.~~ The case manager initiates the UCAT reassessment and development of the new service plan at least 40 days, but not more than 55 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.