CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-761. Eligible providers

ADvantage Program service providers, except pharmacy providers, must be certified by the ADvantage Program ~~Administrative Agent~~ ADvantage Administration (AA) and all providers must have a current signed SoonerCare contract on file with the Medicaid Agency (Oklahoma Health Care Authority).

(1) The provider programmatic certification process ~~shall verify~~ verifies that the provider meets licensure, certification and training standards as specified in the waiver document and agrees to ADvantage Program Conditions of Participation. Providers must obtain programmatic certification to be ADvantage Program certified.

(2) The provider financial certification process ~~shall verify~~ verifies that the provider uses sound business management practices and has a financially stable business. All providers, except for NF Respite, Medical Equipment and Supplies, and Environmental Modification providers, must obtain financial certification to be ADvantage Program certified.

(3) Providers may fail to gain or may lose ADvantage Program certification due to failure to meet either programmatic or financial standards.

(4) At a minimum, the AA reevaluates provider financial certification annually.

(5) The AA relies upon the Oklahoma Department of Human Services (OKDHS)/Aging Services Division (ASD) for ongoing programmatic evaluation of Adult Day Care and Home Delivered Meal providers for continued programmatic certification. Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, CD-PASS, and NF Respite services do not have a programmatic evaluation after the initial certification.

(6) OKDHS/ASD may authorize a legally responsible spouse or legal guardian of an adult member to be Medicaid reimbursed under the 1915(c) ADvantage Program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:

(A) Authorization for a spouse or legal guardian to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

(i) either no other provider is available; or

(ii) available providers are unable to provide necessary care to the member; or

(iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

(i) meet the definition of a service/support as outlined in the federally approved waiver document;

(ii) be necessary to avoid institutionalization;

(iii) be a service/support that is specified in the individual service plan;

(iv) be provided by a person who meets the provider qualifications and training standards specified in the waiver for that service;

(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency for the payment of personal care or personal assistance services;

(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or

(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or

(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or

(IV) spouse or guardian provides assistance/care for the member 35 or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

(C) The spouse or legal guardian who is a service provider will comply with the following:

(i) not provide more than 40 hours of services in a seven day period;

(ii) planned work schedules must be available in advance to the member's Case Manager, and variations to the schedule must be noted and supplied two weeks in advance to the Case Manager unless change is due to an emergency;

(iii) maintain and submit time sheets and other required

documentation for hours paid; and

(iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The AA will monitor through documentation submitted by the Case Manager the following:

(i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual ~~recipient~~ member; and

(ii) face-to-face visits with the ~~recipient~~ member by the Case Manager on at least a semi annual basis.

(7) The ~~AA or~~ OKDHS Aging Service Division (OKDHS/ASD) periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), Comprehensive Home Care, and CD-PASS providers. If due to a programmatic audit, a provider Plan of Correction is required, the AA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the ~~AA and~~ OKDHS/ASD, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

317:30-5-763.1. Medicaid agency monitoring of the ADvantage program

The ~~Medicaid Agency~~ OHCA will monitor the eligibility process and the ADvantage plan of care approval process by reviewing annually a minimum of three percent of ADvantage member service plans and associated member eligibility documents for members selected at random from the total number of members having new, reassessed or closed plans during the most recent 12 month audit period.

(1) The ~~Medicaid Agency~~ OHCA=s monitoring of the ADvantage Program is a quality assurance activity. The monitoring evaluates whether program medical and financial eligibility determinations and plans of care authorizations have been done in accordance with ~~Medicaid Agency~~ OHCA policy and requirements specified in the approved waiver document. The areas evaluated include:

(A) Member eligibility determination;

(B) Member "freedom of choice";

(C) ADvantage certified and ~~Medicaid~~ SoonerCare contracted providers on the plan;

(D) Member acceptance of the plan;

(E) Qualified case managers;
(F) Plan services are goal-oriented services; and,
(G) Plan of care costs are within cost cap guidelines.

(2) At the discretion of the ~~Medicaid Agency~~ OHCA, the random selection of members for audit shall be done by the MMIS or the AA Waiver Management Information System using an algorithm approved by the ~~Medicaid Agency~~ OHCA.

(3) At the discretion of the ~~Medicaid Agency~~ OHCA, the ~~Medicaid Agency~~ OHCA auditor may review records at the AA place of business or have the AA mail or transport copied file documents to the ~~Medicaid Agency~~ OHCA place of business.

(4) Missing documents and/or deficiencies found by the ~~Medicaid Agency~~ OHCA are reported to the AA for correction and/or explanation. Periodic reports of deficiencies are provided to ~~the OKDHS/ASD and~~ the AA.

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-950. Eligible providers

Payment is made only to agencies that have been certified as personal care providers by the Oklahoma State Department of Health and are certified by the ADvantage Program ~~Administrative Agent~~ ADvantage Administration (AA) as meeting applicable federal, state and local laws, rules and regulations. In order to be eligible for payment, the personal care agency must have an approved provider agreement on file with the ~~Medicaid agency~~ OHCA, in accordance with OAC 317:30-3-2.

317:30-5-952. Prior authorization

Eligible members receiving personal care services must have an approved care plan developed by a PC services skilled nurse. For persons receiving ADvatage Program services, the nurse works with the member's ADvantage Program Case Manager to develop the care plan. The amount and frequency of the service, to be provided to the member, is listed on the care plan. The amount and frequency of PC services is approved by the OKDHS nurse or ~~by the Administrative Agent's (AA) authorization of~~ authorized in the ADvantage Program Service Plan. At the time of a ~~PC services~~ member's initial referral to a PC services agency, ~~OKDHS or AA~~ OKDHS/ASD authorizes PC services, skilled nursing for PC services, needs assessment and care plan development. The number of units of PC services or PC skilled nursing the member is eligible to receive is limited to the amounts approved on the care plan as authorized by ~~OKDHS or AA~~ OKDHS/ASD. Care plans are authorized for no more than one year from the date of care plan authorization. Services provided without prior authorization are not compensable.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 1. GENERAL SERVICES

317:35-1-2. Definitions

The following words and terms, when used in this Chapter, ~~shall~~ have the following meaning, unless the context clearly indicates otherwise:

"Acute Care Hospital" means an institution that meets the requirements of 42CFR, Section 440.10 and:

(A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) meets the requirements for participation in Medicare as a hospital.

"~~Administrative agent~~ ADvantage Administration (AA)" means ~~the Long-Term Care Authority who is under contract with~~ the Oklahoma Department of Human Services (OKDHS) ~~to perform~~ which performs certain administrative functions related to the ADvantage Waiver.

"AFDC" means Aid to Families with Dependent Children.

"Aged" means an individual whose age is established as 65 years or older.

"Aid to Families with Dependent Children" means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for Aid to Families with Dependent Children in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all ~~Medicaid clients~~ SoonerCare members related to AFDC.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the Oklahoma Health Care Authority (OHCA).

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the Oklahoma Health Care Authority Board.

"Buy-in" means the procedure whereby the ~~Authority~~ OHCA pays the ~~client's~~ member=s Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the ~~Authority~~ OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the ~~Authority~~ OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for ~~client's~~ members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and when applicable, resources are within the standards for the category to which the ~~client~~ individual is related.

"Categorically related" or "related" means the individual is:

(A) aged, blind, or disabled;

(B) pregnant;

(C) an adult individual who has a minor child under the age of 18 and who is deprived of parental support due to absence, death, incapacity, unemployment; or

(D) a child under 19 years of age.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"County" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

ACSED@ means the Oklahoma Department of Human Services= Child Support Enforcement Division.

ACustody@ means the custodial status, as reported by the Oklahoma Department of Human Services.

"Deductible/Coinsurance" means the payment that must be made by

or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for in-patient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (~~Supplemental~~ Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays 80% of the allowable charge. The remaining 20% is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the ~~recipient's~~ member=s estate as defined in Title 58 of the Oklahoma Statutes.

"Gatekeeping" means the performance of a comprehensive assessment by the ~~LTC~~ OKDHS nurse utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Local office" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

~~**"LTC nurse"** means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The LTC nurse also develops care plans and service plans for Personal Care services based on the UCAT.~~

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of ~~two~~ four separate programs. Part A is Hospital Insurance, ~~(HI) and~~ Part B is ~~Supplemental~~ Medical Insurance, ~~(SMI)~~ Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare ~~(HI)~~"** means Hospital Insurance that covers

services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age 65 or older and for those under age 65 who have been receiving disability benefits under these programs for at least 24 months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age 65 or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for Medicaid benefits as categorically needy. They must however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a Qualified Disabled and Working Individual (QDWI) under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare ~~(SMI)~~"** means ~~Supplemental~~ Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under Authority policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of 18.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for the mentally retarded or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

AOKDHS nurse@ means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Recipient lock-in" means when a ~~recipient~~ member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a ~~Medicaid recipient~~ SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a 12-month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for ~~Medicaid~~ SoonerCare if residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays are expected to last not less than 60 days.

"Worker" means the OKDHS worker responsible for Medicaid eligibility determinations.

SUBCHAPTER 15. PERSONAL CARE SERVICES

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

The ~~Administrative Agent~~ ADvantage Administration (AA) certifies qualified PC service agencies and facilitates the execution of the agencies' SoonerCare contracts on behalf of OHCA. OHCA will check the list of providers that have been barred from Medicare/Medicaid participation to ensure that the PC services agency is not listed.

(1) **Payment for Personal Care.** Payment for PC services is generally made for care in the member's "own home". In addition to an owned or rented home, a rented apartment, room or shelter shared with others is considered to be the member's "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., and/or in any other type of settings prohibited under applicable federal or state statutes, rules, regulations, or other written

instruments that have the effect of law is not a setting that qualifies as the member's "own home" for delivery of PC services through SoonerCare. With prior approval, PC services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the care plan.

(A) **Use of Personal Care service agency.** To provide PC services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by OKDHS or the AA, and possess a current SoonerCare contract.

(B) **Reimbursement.** Personal Care services payment on behalf of a member is made according to the type of service and number of units of PC services authorized in the care plan.

(i) The amount paid to PC services providers for each unit of service is according to the established SoonerCare rates for the PC services. Only authorized units contained on each eligible member's individual care plan are eligible for reimbursement. Providers serving more than one PC service member residing in the same residence will assure that the members' care plans combine units in the most efficient manner possible to meet the needs of all eligible persons in the residence.

(ii) Payment for PC services is for tasks performed in accordance with OAC 317:30-5-951 only when listed on an authorized care plan. Payment for PC skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per assessment/service planning visit by the provider agency personal care skilled nurse.

(2) **Issue resolution.** If the member is dissatisfied with the PC services provider agency or the assigned PCA, and has exhausted attempts to work with the PC services agency's grievance process without resolution, the member may contact the OKDHS nurse to attempt to resolve the issues. The member has the right to appeal to the OHCA in accordance with OAC 317:2-1-2. For members receiving ADvantage services, the member or family should contact their case manager for the problem resolution. If the problem remains unresolved, the member or family should contact the Consumer Inquiry System (CIS). Providers are required to provide the CIS contact number to every member. The ADvantage Program member also has the right to appeal to the OHCA in accordance with OAC 317:2.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

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

(a) **Application date.** If the applicant is found eligible for Medicaid, 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 ~~Administrative Agent~~ 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 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan by the case manager. In addition, an independent evaluation of medical eligibility is completed by the OKDHS Nurse at least every third year. If documentation supports a reasonable expectation that the member will 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, ~~client~~ 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 ~~client~~ member. Within three working days of being assigned an ADvantage ~~client~~ member, the case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the ~~client~~ member, service provider, case manager, ~~Administrative Agent~~ 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 ~~client's~~ member=s UCAT identified

primary physician that the ~~client~~ member has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the ~~client's~~ 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 10 working days of the receipt of ADvantage referral, or the annual re-assessment visit, the case manager completes and submits to the case management supervisor an individualized care plan and service plan for the ~~client~~ member. The care plan and service plan are based on the ~~client's~~ 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 ~~client~~ 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 ~~client~~ member, a nurse from the ADvantage in-home care provider chosen by the ~~client~~ member, and the case manager. Otherwise, the ~~client~~ 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 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 ~~client~~ member signs and indicates review/agreement with the care plan and service plan by indicating acceptance or non-acceptance of the plans. The ~~client~~ member, the ~~client's~~ 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 ~~client~~ member signs with a mark. If the ~~client~~ member refuses to cooperate in development of the service plan, or, if the ~~client~~ 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 nurse or AA may identify ~~clients~~ members that require AA intervention.

(A) For ~~clients~~ members that are uncooperative or disruptive, the AA develops an individualized Addendum to the Rights and Responsibilities Agreement to try to modify the ~~client's~~ member=s uncooperative/disruptive behavior. The rights and responsibilities addendum focuses on behaviors, both favorable and those that jeopardize the consumer's well-being and includes a design approach of incremental plans and addenda that allow the ~~client~~ member to achieve stepwise successes in the modification of their behavior.

(B) The AA may implement a service plan without the ~~client's~~ member=s signature if the AA has developed an Addendum to the Rights and Responsibilities Agreement for the ~~client~~ member. For these ~~clients~~ 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 ~~client~~ 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 the service plan if the AA demonstrates effort to work with and obtain the ~~client's~~ 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 ~~client~~ 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 ~~client~~ member a Case Manager that has successfully completed training on CD-PASS, Independent Living Philosophy and Person-centered planning. 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 ~~clients~~ members. The CDA/CM educates the ~~client~~ member about their rights and responsibilities as well as about community resources, service choices and options available to the ~~client~~ member to meet CD-PASS service goals and objectives.

(B) The ~~client~~ member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing ~~client~~ member employer responsibilities. If the ~~client~~ 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 ~~client~~ member, the designee and the ~~client's~~ 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 ~~client~~ member has legal standing to be the ~~client's~~ member=s designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a ~~client~~ member may not be designated the "authorized representative" for the ~~client~~ member.

(C) The CDA/CM provides support to the ~~client~~ 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 ~~client~~ 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-center 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 ~~client~~ 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 ~~client's~~ 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 ~~client~~ member, or as applicable their designated Aauthorized representative@, to lead, to the extent feasible, the CD-PASS service planning process for Personal Services Assistance. The CDA/CM helps the ~~client~~ member define support needs, service goals and service preferences including access to and use of generic community resources. Consistent with ~~client-direction~~ member-direction and preferences, the CDA/CM provides information and helps the ~~client~~ member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the ~~client~~ member in translating the assessment of ~~client~~ member needs and preferences into an individually tailored,

personalized service plan.

(E) To the extent the ~~client~~ member prefers, the CDA/CM develops assistance to meet ~~client~~ 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 ~~client~~ member determines with the PSA to be hired, a start date for PSA services. The ~~client~~ member coordinates with the CDA/CM to finalize the service plan.

(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 ~~client~~ member and, as appropriate, arranges for training by a skilled nurse for the ~~client~~ member or ~~client's~~ member=s family and the APSA to ensure that the APSA performs the specific Health Maintenance tasks safely and competently;

(i) If the ~~client's~~ member=s APSA has been providing Advanced Supportive Restorative Assistance to the ~~client~~ 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 ~~client~~ member and APSA attest that the APSA has been performing the specific Health Maintenance tasks to the ~~client's~~ 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 ~~client's~~ member=s well being and the quality of supports and services and assists the ~~client~~ member in revising the PSA services plan as needed. If the ~~client's~~ 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 CD-PASS service units appropriate to meet additional ~~client~~ member=s need and forwards the plan amendment to the AA for authorization and update of the ~~client's~~ 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 ~~clients~~ members and ADvantage service providers under the following circumstances:

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

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

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

(K) The CDA/CM and the ~~client~~ member prepare an emergency back-up/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 ~~client~~ 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 ~~client~~ 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 makes a copy of the plans and other

~~client~~ member original documents for the ~~client~~ member=s file, faxes a copy of the plan to the AA and forwards the original care plan and service plan and required documents.

(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 ~~client~~ 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 or new service plan authorization, the case manager visits the ~~client~~ member, gives the ~~client~~ 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 ~~Administrative Agent~~ ADvantage Administration (AA) certifies the individual service plan and all service plan amendments for each ADvantage ~~client~~ member. When the AA verifies ~~client~~ member ADvantage eligibility, plan cost effectiveness, that service providers are ADvantage authorized and Medicaid contracted, and that the delivery of ADvantage services are consistent with the ~~client's~~ 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 ~~client~~ member (spouse or parent of a minor child).

(1) 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 three 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 ~~client~~ 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) The AA authorizes the service plan by entering the

authorization date and signing the submitted service plan. Notice of authorization and a 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 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.

(3) For audit purposes (including SURS 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.

(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 ~~client's~~ 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 ~~client's~~ 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. The AA approves or denies the care plan and service plan changes within two working days of receipt of the plan.

(2) The ~~client~~ 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 ~~client~~ 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 ~~client's~~ 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 UCAT reassessment by the case manager. The case manager, in consultation with AA, makes the determination of need for reassessment. Based on the reassessment and consultation with the AA, the ~~client~~ member may, as appropriate, be authorized for a new service plan or be eligible for a different service program. If the ~~client~~ member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the ~~client's~~ member=s dated signature indicating voluntary withdrawal for ADvantage program services. If unable to obtain the ~~client's~~ 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 ~~client's~~ 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.

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

(a) When ~~DHS or~~ the ~~Administrative Agent~~ 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 ~~DHS~~ OKDHS ~~LTC~~ 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

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

(1) **Hospital discharge.** When the ~~client~~ member returns home from

a hospital or when notified of the ~~client's~~ 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 ~~client~~ member returns home from a NF stay of 30 days or less or when notified of the ~~client's~~ member=s anticipated discharge date the case manager notifies relevant providers, the ~~client's social~~ 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 ~~client~~ member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the ~~client's DHS social~~ 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 ~~client~~ 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 ~~client's~~ member=s case manager provides "institution transition" case management services to assist the ~~client~~ member to re-establish him or herself safely in the home.

317:35-17-20. Case transfer between categories

~~If it becomes necessary to transfer a case from one category to another because of change in age, income, or marital status, a new application is not required. If someone other than the client or guardian signed the original application form and the transfer is to a money payment case, an application with the client's signature is required. The new case is certified retaining the original certification date and redetermination date, using the appropriate code for transfer from the old category and the appropriate effective date which coincides with the closure of the previous case category. Clients, appropriate medical providers and the ADvantage AA are notified of the new case number and category by computer generated notice.~~

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

Either Aging Services or the ~~Administrative Agent~~ ADvantage Administration (AA) forwards information on all certified ADvantage and Personal Care agency providers providing services in the specific ~~DHS~~ 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 ~~DHS~~ OKDHS staff to achieve efficient service delivery. ~~Aging Services and the~~ The AA

~~certify~~ 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 ~~a DHS~~ 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.