**Oklahoma Health Care Authority**

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

**OHCA COMMENT DUE DATE:** January 18, 2022

The proposed policy changes are Permanent Rules. The proposed policy changes were presented at the November 2, 2021 Tribal Consultation. The proposed rule changes will be presented at a Public Hearing on January 18, 2022. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on January 13, 2022 and the OHCA Board of Directors on January 19, 2022.

**REFERENCE: APA WF 21-02B**

**SUMMARY:**
**OHS ADvantage Waiver Services and State Plan Personal Care Services** – The proposed revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority. Updated policy will provide clarity surrounding eligible provider certification and will also modify procedures to reflect current business practices. Final revisions will correct formatting and grammatical errors.

**LEGAL AUTHORITY:**
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 162 of Title 56 of the Oklahoma Statues (56 O.S. § 162); 1915c ADvantage Waiver; 42 C.F.R. Section 440.167

**RULE IMPACT STATEMENT:**

**STATE OF OKLAHOMA**
**OKLAHOMA HEALTH CARE AUTHORITY**

SUBJECT: Rule Impact Statement
APA WF # 21-02B

A. Brief description of the purpose of the rule:

The proposed revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority. Updated policy will provide

clarity surrounding eligible provider certification and will also modify procedures to reflect current business practices. Final revisions will correct formatting and grammatical errors.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The classes of persons affected by the approved amendments are recipients of ADvantage or State Plan Personal Care services and their providers. No cost impacts are anticipated.

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

The classes of persons affected by the approved amendments are recipients of ADvantage or State Plan Personal Care services and their providers. No cost impacts are anticipated

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

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

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

The proposed rule changes are budget neutral.

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

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

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

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

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

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

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

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

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

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

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

Prepared: December 14, 2021

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

**SUBCHAPTER 15. <u>STATE PLAN</u> PERSONAL CARE SERVICES**

**317:35-15-1. Overview of long-term medical care services;**

**relationship to ~~QMBP, SLMB,~~Qualified Medicare Beneficiary Plus (QMBP), Specified Low-Income Medicare Beneficiary (SLMB), and other SoonerCare services and eligibility**

~~Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for individuals with intellectual disabilities (refer to OAC 317:35-9), persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9), Home and Community Based Waiver Services for the Intellectually Disabled (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ADvantage program (refer to OAC 317:35-17), and Personal Care services (refer to this subchapter). Personal Care provides services in the member's own home. Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind, or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMBP or SLMB benefits is not required.~~

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

(1) Care in a nursing facility, per Oklahoma Administrative Code (OAC) 317:35-19;

(2) Public and private intermediate care facility for individuals with intellectual disabilities (ICF/IID), per OAC 317:35-9;

(3) Persons age sixty-five (65) years or older in mental health hospitals, per OAC 317:35-9;

(4) Home and Community-Based Waiver Services for the Intellectually Disabled, per OAC 317:35-9;

(5) Home and Community-Based Waiver Services for the ADvantage program, per OAC 317:35-17; and

(6) State Plan Personal Care services, per OAC 317:35-15.

(b) State Plan Personal Care provides services in the member's own home. Any time an individual is certified as eligible for long-term care SoonerCare coverage, the member is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind, or disabled individual is determined eligible for long-term care, a separate determination is made to check if the member meets eligibility conditions as a QMBP or an SLMB. Another application for QMBP or SLMB benefits is not required.

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

(a) ~~Personal care~~SPPC services ~~is assistance to an individual~~assist a member in carrying out Activities of Daily

Living (ADLs) or ~~in carrying out~~ Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs ~~to prevent~~. SPPC services prevent or minimize physical health regression or deterioration. ~~Personal care service requires~~SPPC services require a skilled nursing assessment to: ~~of need, development of a care plan to meet identified personal care needs, care plan oversight, and periodic re-assessment and updating, of the care plan, when necessary. Personal care services do not include technical services, such as suctioning, tracheal care, gastrostomy-tube feeding or care, specialized feeding due to choking risk, application of compression stockings, bladder catheterization, colostomy irrigation, wound care, application of prescription lotions or topical ointments, range of motion exercises, or the operation of equipment of a technical nature, such as a patient lift or oxygen equipment.~~

(1) Assess a member's needs;

(2) Develop a care plan to meet the member's identified personal care needs;

(3) Manage care plan oversight; and

(4) Periodically reassess and update the care plan when necessary.

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

(1) Suctioning;

(2) Tracheal care;

(3) Gastrostomy-tube feeding or care;

(4) Specialized feeding due to choking risk;

(5) Applying compression stockings;

(6) Bladder catheterization;

(7) Colostomy irrigation;

(8) Wound care;

(9) Applying prescription lotions or topical ointments;

(10) Range of motion exercises; or

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

~~(b)~~(c) ~~Personal care~~SPPC members may receive services in limited types of living arrangements~~. The specific living arrangements are set forth below.~~ as per (1) through (4) of this subsection.

(1) ~~Personal care~~SPPC members are not eligible to receive services while residing in an institutional setting including, but not limited to~~,~~: ~~licensed facilities, such as a hospital, nursing facility, licensed residential care facility or licensed assisted living facility, or in an unlicensed institutional living arrangement, such as a room and board home or facility. Personal care may not be approved when the client lives in the personal care assistant's home except with the approval of Oklahoma Department of Human Services (DHS) Aging Services.~~

(A) Licensed facilities, such as a:

(i) Hospital;

(ii) Nursing facility;

(iii) Licensed residential care facility; or

(iv) Licensed assisted living facility; or

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

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

(~~2) Additional living arrangements in which members~~(3) Members may receive ~~personal care services are~~SPPC services in the member's own home, apartment, or a family member's or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit including a bathroom and food ~~storage/preparation~~storage and preparation amenities in addition to ~~bedroom/living~~bedroom and living space.

~~(3)~~(4) For ~~personal care~~SPPC members who are full-time students, a dormitory room qualifies as an allowable living arrangement ~~in which~~ to receive ~~personal care services for the period during which the member is a student.~~SPPC services.

~~(4)~~(5) With prior OKDHS Health Care Management Nurse III approval ~~of the DHS area nurse, personal care~~SPPC services may be provided in an educational or employment setting to assist the member to achieve vocational goals identified in the care plan.

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

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

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

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

(4) ~~not be~~Are not convicted of a crime ~~or~~and do not have ~~any~~a criminal background history or registry listings that prohibit employment per ~~O.S. Title 63, Section 1-1950.1;~~Title 63 of the Oklahoma Statutes Section 1-1944 through 1-948;

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

(6) ~~not be~~Are not a legally responsible family member~~, such as a spouse, legal guardian, or parent of a minor child~~ of the member being served, such as a spouse, legal guardian, or a minor child's parent ~~exceptions may be made for a legal guardian to provide services only with prior approval from DHS Aging Services~~;

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

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

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

**317:35-15-3. Application for State Plan Personal Care (SPPC) services**

(a) **Requests for ~~Personal Care.~~SPPC services.** ~~A request for Personal Care is made to the local OKDHS office or ADvantage Administration (AA).~~ The SPPC application process initiates when an online application is completed for SPPC services. A written financial application is not required for an ~~individual~~applicant who has an active SoonerCare case. A financial application for ~~Personal Care~~SPPC services is initiated when there is no active SoonerCare case. The Medicaid application is signed by the applicant, parent, spouse, guardian or someone ~~else~~ acting on the applicant's behalf. All financial eligibility conditions ~~of financial eligibility must be~~are verified and documented in the case record. When current available information ~~already available in the local office~~ establishes eligibility, the 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~~his or her guardian, or a person acting on the applicant's behalf, such as an authorized representative or power-of-attorney, ~~must sign~~signs the application form.

(b) **~~Date of application.~~Application date.** The application date is

the date entered in the electronic system. An exception occurs when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contract provider forwards the application and documentation to the OKDHS county office or to Medicaid Services Unit-ADvantage Administration for SoonerCare eligibility determination.

~~(1) The date of applications is:~~

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

~~(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 SoonerCare is made orally and the financial application form is signed later.~~

~~(2) An exception to paragraph (1) of this subsection would occur when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contract provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for SoonerCare eligibility determination. The application date is the date the applicant signed the application form for the provider.~~

(c) **Eligibility status.** Financial and medical eligibility ~~must be~~is established before services can be initiated.

**317:35-15-4. ~~Determination of~~State Plan Personal Care (SPPC) services medical eligibility ~~for Personal Care~~ determination**

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

(1) ~~have~~Has adequate informal supports ~~consisting of~~. This means there is adult supervision that is present or available to contribute to care~~,~~ or decision-making ability, as documented on the UCAT ~~Part III, to~~. To remain in his or her

home without risk to his or her health, safety, and well-being, the ~~individual:~~applicant:

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

(B) ~~who has his or her~~Has his or her decision-making ability, ~~but~~ lacks the physical capacity to respond appropriately to situations that jeopardize health and safety, and ~~was informed by the DHS nurse~~an OKDHS HCMN I or II informed him or her of potential risks and consequences~~, may be eligible.~~of remaining in the home.

(2) ~~require a plan of care involving the planning and administration of services delivered under the supervision of professional personnel;~~Requires a care plan for planning and administering services delivered under a professional personnel's supervision;

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

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

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

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

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

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

(A) ~~bathing;~~Bathing;

(B) ~~eating;~~Eating;

(C) ~~dressing;~~Dressing;

(D) ~~grooming;~~Grooming;

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

(F) ~~mobility;~~Mobility;

(G) ~~toileting;~~Toileting; and

(H) ~~bowel/bladder~~Bowel or bladder control.

(2) **"ADLs score of three (3) or greater"** means the applicant or member cannot do at least one (1) ADL at all or needs some help with two (2) or more ADLs.

(3) **"~~Consumer~~Applicant or Member support very low ~~need~~"** means the applicant's or member's UCAT ~~Part III Consumer~~ Support score is zero (0), ~~which~~this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal sources are sufficient for the applicant's or member's present need level ~~of member need~~ in most functional areas.

(4) **"~~Consumer~~Applicant or Member support low ~~need~~"** means the member's UCAT ~~Part III Consumer~~ Support score is five (5), ~~which~~this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the support from formal and informal sources are nearly sufficient for the applicant's or member's present need level ~~of member need~~ in most functional areas. The applicant or member, family, or informal supports are meeting most needs typically expected of family or household members to share or do for one another, such as general household maintenance. There is little risk of institutional placement with loss of current supports.

(5) **"~~Consumer~~Applicant or Member support moderate ~~need~~"** means the UCAT ~~Part III Consumer~~applicant or member score is fifteen (15), ~~which~~this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The applicant or member requires additional assistance that usually includes personal care assistance with one (1) or more ADLs not available through Medicare, the Veterans Administration, or other federal entitlement programs. ~~Support provided by informal caregivers is of questionable reliability due to one (1) or more of the following:~~Informal caregiver support is considered questionable or unreliable due to one (1) or more criteria in (A) through (D) of this paragraph:

(A) ~~care~~Care or support is required continuously with no relief or backup available;

(B) ~~informal~~Informal support lacks continuity due to conflicting responsibilities such as work or child care;

(C) ~~care or support is provided by persons~~Persons with

advanced age or disability~~; or~~ provide care; or

(D) ~~institutional~~Institutional placement can reasonably be expected with any loss of existing support.

(6) **"~~Consumer~~Applicant or member support high ~~need~~"** means the member's UCAT ~~Part III~~ Consumer score is twenty-five (25) ~~which~~this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal supports are not sufficient as there is very little or no support available to meet ~~a~~the applicant's or member's high degree of ~~member~~ need.

(7) **"Community ~~services worker~~"Services Worker"** means any non-licensed health professional employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities.

(8) **"Community Services Worker Registry"** means ~~a~~an OKDHS established registry established by the ~~DHS,~~OKDHS per Section (§) 1025.1 of Title 56 of the Oklahoma Statutes (O.S.) ~~to list~~listing community services workers ~~against whom~~who have a final investigative finding of abuse, neglect, or exploitation, per 43A O.S. § 10-103, involving a frail elderly~~,~~ person, ~~disabled person(s),~~ or person(s) with developmental or other disabilities was made by ~~DHS~~OKDHS or an administrative law judge~~; and amended in 2002, to include the listing of SoonerCare (Medicaid) personal care assistants (PCAs) providing personal care services~~.

(9) **"Instrumental ~~activities of daily living (IADL)~~"Activities of Daily Living (IADL)"** means those daily activities that reflect the applicant or member's ability to perform household chores and tasks within the community essential for sustaining health and safety, such as:

(A) ~~shopping;~~Shopping;

(B) ~~cooking;~~Cooking;

(C) ~~cleaning;~~Cleaning;

(D) ~~managing~~Managing money;

(E) ~~using~~Using a phone;

(F) ~~doing~~Doing laundry;

(G) ~~taking~~Taking medication; and

(H) ~~accessing~~Accessing transportation.

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

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

(12) **"MSQ"** means the ~~mental status questionnaire.~~Mental Status

Questionnaire.

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

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

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

(c) **Medical eligibility minimum criteria for ~~personal care~~SPPC.** The medical eligibility minimum criteria for ~~personal care~~SPPC services are the minimum UCAT ~~Part III~~ score criteria that ~~a~~an applicant or member ~~must meet~~meets for medical eligibility ~~for personal care and~~ are:

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

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

(d) **Medical eligibility determination.** ~~Medical~~OKDHS HCMN III determines medical eligibility for ~~personal care~~SPPC services ~~is determined by the DHS. The medical decision for personal care is made by the DHS area nurse~~ utilizing the UCAT Part III.

(1) Categorical relationship ~~must be~~is established for SPPC services financial eligibility determination ~~of eligibility for personal care. When categorical relationship to Aid to the Disabled was not established but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1. The licensed health care professional cannot be in a medical facility internship, residency, or fellowship program or in the full time employment of the Veterans Administration, United States Public Health Service, or other agency. The DHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA)~~

~~definition. A follow-up is required by the DHS county worker with (SSA) to ensure the SSA disability decision is also the LOCEU decision.~~

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

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

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

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

(2) Approved contract agencies or the ADvantage Administration (AA) may complete ~~UCAT Part I for intake and screening and forward the form to the county office.~~the electronic application, this alerts the social services specialist (SSS) of application date.

(3) Upon ~~receipt of the referral, DHS county staff may initiate the UCAT, Part I.~~referral receipt, OKDHS SSS starts the financial eligibility determination.

(4) The ~~DHS nurse~~OKDHS HCMN I or II is responsible for completing the UCAT Part III assessment visit within ~~ten-business (10-business)~~ten (10) business days of the personal care ~~referral~~application for the applicant who is SoonerCare eligible at the time of the request. The ~~DHS nurse~~OKDHS HCMN I or II completes the assessment visit within ~~twenty-business (20-business)~~twenty (20) business days of the referral for the applicant not determined SoonerCare eligible at the time of the request. When the ~~UCAT Part I~~application indicates the request is from an individual who resides at home and an immediate response is required to ensure the applicant's health and safety ~~of the person~~, to prevent an emergency situation, or to avoid

institutional placement, the UCAT ~~Part III~~ assessment visit has top-scheduling priority.

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

(A) When SPPC services are not sufficient to meet the applicant's or member's needs~~ cannot be met by personal care services alone~~, the ~~DHS nurse informs the applicant of the~~OKDHS HCMN I or II provides information about other community long-term care service options. The ~~DHS nurse~~OKDHS HCMN I or II assists ~~the applicant~~ in accessing service options ~~selected by~~ the applicant or member selects in addition to, or in place of, ~~Personal Care~~SPPC services.

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

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

(6) The ~~DHS nurse~~OKDHS HCMN I or II completes the UCAT ~~Part III~~in the electronic system and ~~sends it to~~ the ~~DHS area nurse for~~OKDHS HCMN III makes the medical eligibility determination. ~~Personal care~~SPPC service eligibility is established on the date medical eligibility is approved and financial eligibility is established. This date serves as the certification date for

services to be initiated.

(A) When the time length ~~of time~~ from the initial assessment to the date of service eligibility determination exceeds ~~ninety-calendar (90-calendar)~~ninety (90) calendar days, a new UCAT ~~Part III~~ and assessment ~~visit~~ is required.

(B) The ~~DHS area nurse~~OKDHS HCMN III assigns a medical certification period of not more than thirty-six (36) months for persons eighteen (18) years of age and older or not more than twelve (12) months for persons younger than eighteen (18) years of age. The service plan period ~~under the Service Authorization Model (SAM)~~ is for ~~a period of~~ twelve (12) months ~~and is provided by the DHS nurse~~.

(7) The ~~DHS area nurse notifies the DHS county worker~~SSS is notified via ~~Electronic Data Entry and Retrieval System (ELDERS)~~the electronic system of the personal care certification. ~~The authorization line is open via automation from ELDERS.~~

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

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

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

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

**317:35-15-5. General financial eligibility requirements for State Plan Personal Care**

Financial eligibility for ~~Personal Care~~SPPC is determined using

the rules on income and resources according to the eligibility group ~~to which~~ the ~~individual~~member is related~~.~~ to. Income and resources are evaluated on a monthly basis for all ~~individuals~~ members requesting payment for ~~Personal Care~~SPPC who are categorically related to ~~ABD;~~Aged, Blind, or Disabled (ABD); maximum countable monthly income and resource standards for individuals related to ABD are found on ~~OKDHS~~Oklahoma Human Services (OKDHS) form 08AX001E (Appendix C-1), Schedule VI ~~(QMBP program standards).~~Qualified Medicare Beneficiary Plus program standards.

**317:35-15-6. Determining financial eligibility of categorically needy individuals**

Financial eligibility for ~~Personal Care~~State Plan Personal Care (SPPC) services for categorically needy individuals is determined as follows:

(1) **Financial eligibility for ~~MAGI~~Modified Adjusted Gross Income (MAGI) eligibility groups.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility ~~for MAGI eligibility groups~~.

(2) **Financial ~~eligibility/categorically~~eligibility or categorically related to ~~ABD.~~Aged, Blind, and Disabled.** In determining income and resources for the ~~individual~~member related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income ~~must be~~is less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule VI ~~(QMBP standard).~~Qualified Medicare Beneficiary Plus standard. If ~~an individual and~~a memberand his or her spouse cease to live together for reasons other than institutionalization or receipt of the ADvantage waiver or HCBW/MR services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts ~~which are actually contributed~~ to the spouse after the mutual consideration has ended are considered.

(3) **Determining financial eligibility for State Plan Personal Care~~.~~ (SPPC).** For individuals determined categorically needy for ~~Personal Care,~~SPPC, the member will not pay a vendor payment for ~~Personal Care~~SPPC services.

**317:35-15-7. Certification for State Plan Personal Care**

(a) **State Plan Personal Care (SPPC) certification period.** The first month of the ~~Personal Care~~SPPC certification period ~~must be~~is the first month the member ~~was~~is determined financially and medically eligible for ~~Personal Care,~~to receive SPPC ~~both financially and medically~~. When eligibility or ineligibility for ~~Personal Care~~SPPC

is established, the local OKDHS office updates the computer-generated ~~form~~notice and the appropriate notice is mailed to the member.

(b) **Financial certification period.** The financial certification period for ~~Personal Care~~SPPC services is ~~12~~twelve (12) months. ~~Redetermination of eligibility~~Eligibility redertmination is completed according to the categorical relationship.

(c) **Medical certification period.** A medical certification period of not more than thirty-six (36) months is assigned for an ~~individual~~member who is approved for ~~Personal Care.~~SPPC. The certification period for ~~Personal Care~~SPPC services is based on the Uniform Comprehensive Assessment Tool ~~(UCAT)~~ evaluation and clinical judgment of the Oklahoma ~~Department of~~ Human Services ~~(DHS) area nurse or designee.~~HCMN III.

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

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

(1) ~~02AG044E, Personal Care Progress Notes;~~Adv/SPPC-Nurse Evaluation;

(2) ~~02AG030E, Personal Care Planning Schedule/Service Plan;~~SPPC-Service Planning; and

(3) ~~02AG029E, Personal Care Plan.~~SPPC Member Service Agreement.

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

(c) The personal care provider agency receives documentation from ~~DHS as~~the OKDHS HCMN I or II for authorization to begin services.

The agency ~~delivers~~provides a copy of the ~~care~~ plan ~~Form 02AG029E and the Personal Care Planning Schedule/Service Plan~~ to the member upon initiating services.

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

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

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

(2) The provider agency nurse makes a ~~SAM home~~monitoring visit using the Adv/SPPC Nurse Evaluation at least every six (6) months to assess the member's satisfaction with his or her care and to evaluate the ~~SAM packet~~care plan for adequacy of goals and authorized units. Whenever a ~~home~~monitoring visit is made, the provider agency nurse documents findings in the ~~Personal Care Progress Notes.~~electronic system. The provider agency ~~forwards a copy of the Progress Notes~~ to the ~~DHS nurse~~HCMN I or II for review within ~~five-business~~five (5) business days of the visit. A registered nurse (RN) conducts the monitoring visit when the PCA is performing hands-on personal care. ~~The~~A licensed practical nurse may only conduct the monitoring visit ~~may be conducted by a Licensed Practical Nurse (LPN) only~~ when the PCA is not performing hands-on personal care. ~~A Registered Nurse (RN) must also co-sign~~An RN also co-signs the progress notes.

(3) ~~Requests by the~~The provider agency ~~nurse~~nurse's requests to change the number authorized of units ~~authorized~~ in the ~~SAM packet~~SPPC plan are submitted via the electronic system to ~~(DHS)~~the OKDHS HCMN III ~~and are approved or denied by the (DHS) area nurse or designee,~~to approve or deny prior to changed number of units ~~unit~~ implementation.

(4) Annually, or more frequently when the member's needs change, the provider agency nurse re-assesses the member's ~~need's~~needs and develops a new ~~SAM packet~~plan to meet the member's needs. The provider agency nurse ~~conducts a home visit and~~ completes

and submits the annual reassessment documents to the ~~DHS nurse~~OKDHS HCMN I or II no sooner than ~~60-calendar~~sixty (60) calendar days before the existing service plan end-date, and no later than ~~14-calendar~~fourteen (14) calendar days prior to service.

(5) When the member is unstaffed, the provider agency nurse or staff communicates with the member and makes efforts to re-staff. ~~It is recommended the provider agency contacts unstaffed members weekly by phone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff.~~When consecutively unstaffed for seven (7) calendar days, or fewer depending on the member's needs, the provider agency nurse or staff contacts the unstaffed member weekly by phone to actively monitor the member's health and safety and documents ongoing efforts to provide staff using the electronic system. When the member is unstaffed for ~~30-calendar~~thirty (30) days, the provider agency notifies the ~~DHS~~OKDHS nurse on Form 02AG032E, Provider Communication Form. The ~~DHS nurse~~OKDHS HCMN I or II via the Case Note for SPPC thirty (30) day unstaffed note in the electronic system. The HCMN I or II contacts the member and when the member chooses, initiates a member transfer ~~of the member~~ to another provider agency that can provide staff.

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

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

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

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

(B) **Reimbursement.** ~~Personal care~~SPPC services payment on a member's behalf ~~of a member~~ is made according to the service type ~~of service~~ and number of ~~units of personal care services authorized in the Service Authorization Model (SAM)~~

~~packet.~~authorized service units.

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

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

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

(2) **Issue resolution.**

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

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

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

~~care~~SPPC services~~ (exceptions may be made for legal guardians with prior approval from the Department of Human Services/Aging Services (DHS/AS)~~.

**317:35-15-8.2. State Plan Personal Care Eligible Provider Exception [REVOKED]**

~~The Oklahoma Department of Human Services (OKDHS) Aging Services (AS) may authorize a member's legal guardian to be eligible for SoonerCare (Medicaid) reimbursement when he or she is hired by a home care provider agency as a personal care service provider. Authorization for a legal guardian as a provider requires the criteria in (1) though (4) of this Section and monitoring provisions to be met.~~

~~(1) Authorization for a legal guardian to be the member's care provider may occur only when the member is offered a choice of providers and documentation demonstrates:~~

~~(A) Another provider is not available; or~~

~~(B) The member's needs are so extensive that the legal guardian providing the care is prohibited from obtaining employment.~~

~~(2) The service must:~~

~~(A) Fall under the State Plan Personal Care (SPPC) program guidelines;~~

~~(B) Be necessary to avoid institutionalization;~~

~~(C) Be a service and/or support specified in the person-centered service plan;~~

~~(D) Be provided by a person who meets provider qualifications;~~

~~(E) Be paid at a rate that does not exceed what would be paid to a provider of a similar service and does not exceed what is allowed by Medicaid (SoonerCare)for the payment of personal care or personal assistance services; and~~

~~(F) Not be an activity the legal guardian would ordinarily perform or is responsible to perform.~~

~~(3) The legal guardian service provider complies with:~~

~~(A) Providing no more that forty (40) hours of services in a seven (7) calendar day period;~~

~~(B) Planned work schedules that must be available in advance for the member's home care agency. Variations to the schedule must be noted and supplied to the home care agency two (2) weeks in advance unless the change is due to an emergency;~~

~~(C) Utilization of the Electronic Visit Verification System (EVV) also known as the Interactive Voice Response Authentication (IVRA) system; and~~

~~(D) Being identified and monitored by the home care agency.~~

~~(4) The home care agency is required to submit a request and obtain approval for eligible provider exceptions to OKDHS AS~~

~~prior to employing a legal guardian as a member's personal care assistant (PCA). Eligible provider exceptions require the home care agency to:~~

~~(A) Provide monitoring and complete the Eligible Provider Exception Six Month Review document, when in the member's home completing the six-month Nurse Evaluation document in the Medicaid waiver information system; and~~

~~(B) Annually complete the Eligible Provider Exception Request and submit it with the annual Service Authorization Model (SAM) documentation no later than forty-five (45) calendar days prior to the previous eligible provider exception service authorization end date.~~

**317:35-15-9. Redetermination of financial eligibility for State Plan Personal Care**

The OKDHS county Social Services Specialist must complete a redetermination of financial eligibility before the end of the certification period. A notice is generated only if there is a change which affects the member's financial eligibility.

**317:35-15-10. ~~Redetermination of medical~~Medical eligibility redetermination for ~~personal care~~State Plan Personal Care (SPPC) services**

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

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

(c) **Change in amount of units or tasks.** When the ~~personal care~~SPPC

provider agency determines a need for a change in the amount of units or tasks ~~within the personal care~~in the service, a ~~new Service Authorization Model (SAM) packet~~care plan is completed and submitted to ~~DHS~~OKDHS within five (5) business days of identifying the assessed need. The OKDHS HCMN III approves or denies the change ~~is approved or denied by the DHS area nurse or designee,~~ prior to implementation.

(d) **~~Voluntary closure of personal care services.~~SPPC services voluntary closure.** When a SPPC member decides personal care services are no longer needed to meet his or her needs, a medical decision is not needed. The member ~~and the DHS nurse or DHS county Social Services Specialist completes and signs DHS Form 02AG038E, State Plan Personal Care/ADvantage Program~~is sent a Voluntary Withdrawal Request~~.~~ for confirmation and signature, and the request is entered into the electronic system upon receipt. ~~The DHS nurse submits~~A closure notification is submitted to the provider agency~~.~~ via the electronic system.

(e) **Resuming personal care services.** When a SPPC member approved for ~~personal care~~SPPC services is without ~~personal care~~ services for less than ~~ninety-calendar (90-calendar)~~ninety (90) calendar days, but the member has current medical and SoonerCare (Medicaid) financial eligibility approval, ~~personal care~~SPPC services may be resumed using the member's previously approved ~~SAM packet.~~plan. The personal care provider agency nurse contacts the member to determine when changes in health or service needs occurred. When changes are identified, the provider agency nurse ~~makes a home~~completes an assessment visit and submits ~~a personal care~~a SPPC services skilled nursing need re-assessment ~~of need~~ within ~~ten-business (10-business)~~ten (10) business days of the resumed plan start date~~, using the State Plan Personal Care Progress Notes, DHS Form 02AG044E~~. When the member's needs dictate, the personal care provider agency may submit a request for a change in authorized ~~personal care services~~SPPC service units ~~with a SAM packet to DHS~~. When no changes occur, the agency nurse documents the contact ~~on State Plan Personal Provider Communication Form 02AG032E and forwards it to the DHS nurse within ten-business (10-business)~~in the electronic system for the OKDHS HCMN I or II ten (10) business days of the resumed plan start date.

(f) **Financial ineligibility.** When the ~~DHS~~OKDHS social services specialist (SSS) determines a ~~personal care services~~ member does not meet SoonerCare (Medicaid) financial eligibility criteria, the ~~DHS office notifies the DHS area nurse~~OKDHS HCMN III is notified to initiate the closure process due to financial ineligibility. ~~Individuals determined~~When OKDHS determines a member to be financially ineligible for ~~personal care~~SPPC services, ~~are notified by DHS~~they notify the member of the determination, and his or her right to appeal the decision, in writing of the

determination and of their right to appeal the decision. ~~The DHS nurse submits~~A closure notification is submitted to the provider agency.

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

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

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

(3) ~~whose~~Whose medical eligibility redetermination is not made by applicable extended deadline, the member is determined to be ~~no longer~~ medically ~~eligible;~~ineligible; or

(4) ~~who~~Who no longer meet medical eligibility or cannot be located to complete the redetermination assessment, ~~the area nurse or nurse designee,~~the HCMN I or II notifies the HCMN III. The HCMN III updates the system's medical eligibility end date and notifies the ~~DHS State Plan Care Unit (SPCU) nurse~~HCMN I or II of effective end date. The ~~DHS SPCU nurse submits~~A closure notification is submitted to the provider agency.

(h) **~~Termination of~~ State Plan ~~personal care services.~~Personal Care services termination.**

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

(A) ~~the~~Professional documentation supports the member poses a threat to self or others~~ as supported by professional documentation~~;

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

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

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

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

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

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

(H) ~~the~~The member refuses to select ~~and/or~~or accept ~~the services of~~ a provider agency or ~~personal care assistant (PCA)~~Personal Care Assistant (PCA) service for ~~ninety consecutive (90-consecutive)~~ninety (90) consecutive days as ~~supported by~~ professional or credible documentation~~.~~ supports.

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

**317:35-15-12. Case changes**

Any time there are changes ~~which affect~~affecting the State Plan

Personal Care case~~,~~ eligibility, computer generated notices are issued.

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

(a) An Individual Personal Care Assistant (IPCA) may be utilized to provide ~~personal care~~SPPC services when it is documented to be in the member's best interest ~~of the member~~ to have an IPCA, or when there are no qualified personal care provider agencies available in the member's local area. Oklahoma Health Care Authority (OHCA) checks the list of providers barred from Medicare/Medicaid participation to ensure the IPCA is not listed.

(b) After ~~personal care~~SPPC services eligibility is established, and prior to implementation of ~~personal care~~SPPC services using an IPCA, the ~~DHS nurse~~OKDHS Health Care Management Nurse I or II reviews the care plan with the member and IPCA and notifies ~~the member and IPCA~~them to begin ~~personal care~~SPPC services delivery. The ~~DHS nurse~~OKDHS HCMN I or II maintains the original care plan and forwards a copy ~~of the care plan~~ to the selected IPCA and member within ~~one-business~~one (1) business day of approval receipt ~~of approval~~.

(c) The ~~DHS nurse~~HCMN I or II contacts the member within ~~five-business~~five (5) business days to ensure services are in place and meeting the member's needs. The HCMN I or II also ~~and~~ monitors the care plan for members with an IPCA. For any member receiving ~~personal care~~SPPC services utilizing an IPCA, the ~~DHS nurse~~OKDHS HCMN I or II makes a home visit at least every six (6) months beginning within ~~90-calendar~~ninety (90) calendar days from the date of ~~personal care~~ service initiation. ~~DHS~~OKDHS HCMN I or II assesses the member's satisfaction with his or her ~~personal care~~SPPC services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan ~~must be~~are approved by the ~~DHS area nurse or designee,~~HCMN III prior to implementation ~~of the changed number of units~~.

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

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

(1) **IPCA payment.** Payment for ~~personal care~~SPPC services is

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

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

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

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

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

(iv) A member may select more than one (1) IPCA. ~~This may be~~The service and care plan indicates when this is necessary ~~as indicated by the service and care plans~~.

(v) The IPCA may provide SoonerCare ~~personal care~~SPPC services for several households during one (1) week as long as the daily number of paid service units does not exceed eight (8) hours, ~~32~~thirty-two (32) units per day. ~~The total number of~~Total weekly hours ~~per week~~ cannot exceed ~~40, 160 units.~~forty (40), one-hundred and sixty (160) units.

(B) **~~Release of~~IPCA wage ~~and/or~~or employment information ~~for IPCAs.~~release.** Any inquiry received by the local office requesting wage ~~and/or~~or employment information ~~for an IPCA~~ is forwarded to~~ the~~ OHCA, Claims Resolution.

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

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

(B) **Persons ineligible to serve as IPCAs.** ~~Payment~~SPPC services payment from SoonerCare funds ~~for personal care services~~ may not be made to an individual who is ~~a~~the member's legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served~~, exceptions to legal guardian are made only with prior approval from Aging Services Division~~.

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

(ii) If it is determined that ~~an a DHS~~an OKDHS HCMN I or II or an OHCA employee is interfering in ~~the process of providing services~~service provision for personal or family benefit, ~~he or she~~the employee is subject to disciplinary action.

(3) **IPCA orientation.** When a member selects an IPCA, the ~~DHS nurse contacts~~OKDHS HCMN I or II notifies the ~~individual~~selected IPCA ~~to report to the county office~~ to complete the Oklahoma State Department of Health~~ form~~(OSDH)

Form 805, Uniform Employment Application for Nurse Aide Staff, and the ~~DHS~~OKDHS Form 06PE039E, Employment Application Supplement, and for a qualification determination ~~of qualifications~~ and orientation~~.~~ determination. For ~~personal care~~SPPC members, this process is the ~~responsibility of the DHS nurse.~~OKDHS HCMN I or II responsibility. The IPCA can begin work ~~when:~~after:

(A) ~~he or she was interviewed by the member,~~The member interviews him or her;

(B) ~~he or she was oriented by the~~The OKDHS nurse~~,~~ orients him or her;

(C) ~~he or she executed a~~A contract (OHCA-0026) is executed with the OHCA~~,~~;

(D) ~~the~~The effective service date ~~was~~is established~~,~~;

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

(F) ~~the Oklahoma State Department of Health~~OSDH Nurse Aide Registry ~~was~~is checked and no notations ~~were~~are found~~,~~; and

(G) ~~the~~ OSBI background check ~~was~~is completed.

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

(5) **Problem resolution related to ~~the~~IPCA performance ~~of the IPCA~~.** When it comes to ~~the attention of~~ the ~~DHS nurse that~~OKDHS HCMN I or II attention there is a problem related to ~~the~~ IPCA performance ~~of the IPCA~~, a counseling conference is held between the member, OKDHS ~~nurse,~~HCMN I or II, and ~~worker.~~IPCA. The ~~DHS nurse~~OKDHS HCMN I or II counsels the IPCA regarding problems with his or her performance~~. Counseling is considered when staff believes counseling will result~~ when doing so results in improved performance.

(6) **~~Termination of the~~ IPCA Provider Agreement~~.~~ termination.**

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

(i) ~~an IPCA's performance is such that his or her continued participation in the program could pose~~Performance poses a threat to the member's health and safety ~~of the member~~ or to others; or

(ii) ~~the IPCA failed~~Failed to comply with ~~the expectations outlined in the~~ PCA Provider Agreement expectations and counseling is not appropriate or ~~was not~~ effective; or

(iii) ~~an IPCA's name~~Name appears on the ~~DHS~~OKDHS Community Services Worker Registry~~,~~ or any ~~of the registries~~registry listed in ~~Section 1-1947 of Title~~O.S.

63 ~~of the Oklahoma Statutes,~~ § 1-1947, even ~~though his or her name may not have appeared on the Registry~~when his or her name is not on the registry at the time of application or hiring.

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

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

**317:35-15-14. Billing procedures for State Plan personal care**

Billing procedures for ~~personal care~~State Plan Personal Care (SPPC) services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through ~~a study of~~studying the manual are referred to the Oklahoma Health Care Authority (OHCA). ~~Contractors for Personal Care~~SPPC contractors bill on CMS-1500 claim form. OHCA provides instructions to ~~an~~a contracted Individual ~~personal care assistant~~Personal Care Assistant (IPCA) ~~contracted provider~~ for claim completion ~~of the claim~~ at the ~~time of the contractor~~contractor's orientation. The contracted provider submits a claim for each member. The contracted provider prepares claims for services provided and submits the claims to the fiscal agent responsible for ensuring claims ~~were~~are properly completed. All personal care contractors must have a unique provider number. New contracted providers are mailed the provider number after ~~they are~~being placed on the claims processing contractor's provider file. All services provided in the ~~service recipients~~member's home, ~~member's home~~ including Personal Care and Nursing ~~must be~~, and all work completed in the provider's office, are documented through the Electronic Visit Verification (EVV) system. ~~Additionally, work completed in the provider's office is documented in the EVV system.~~ The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of an EVV system failure, the provider documents time in accordance with internal provider agency policy and procedures backup plan. This documentation is sufficient to account for both

in-home and in-office services. The provider agency's backup procedures are only permitted when the EVV system is unavailable.

**317:35-15-15. ~~Referral for social services~~Social services referral**

In many situations, members ~~who are~~ receiving medical services through SoonerCare (Medicaid) need social services. The OKDHS ~~nurse~~HCMN I or II may make referrals for social services to the OKDHS ~~worker~~social services specialist (SSS) in the local office. In addition to these referrals, a member, or another individual acting on the member's behalf, may initiate a social services request~~ for social services may be initiated by a member or by another individual acting upon behalf of a member~~.

(1) ~~The~~ OKDHS ~~Social Services Specialist~~SSS ~~is responsible for providing~~provides the indicated services, or ~~for referral~~makes referrals to the appropriate ~~resource outside the Department~~outside resources if the services are not available within ~~the Department.~~OKDHS.

(2) ~~Among the~~OKDHS SSS provided services~~ provided by the OKDHS Social Services Specialist are:~~

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

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

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

(D) ~~Services to promote~~Promote member's maximum independence in ~~the management of~~managing their own affairs;

(E) ~~Protective~~Include protective services~~, including evaluation of~~ that evaluate the need for and ~~arranging for~~arrange guardianship; and

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

## SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

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

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

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

(A) ~~DHS~~OKDHS nurse ~~is responsible for completing~~completes the UCAT~~ III~~; and

(B) ~~social service~~Social services specialist (SSS) ~~is responsible for contacting~~contacts the applicant within three (3) business days to initiate the financial eligibility application process.

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

(3) Community agencies and waiver service applicants may complete the UCAT~~ I~~, and forward ~~the form~~ to ~~the county office.~~OKDHS. ~~When the UCAT I indicates the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources. Members may call the care line at 1-800-435-4711.~~

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

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

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

(B) Applicants are not denied access to the waiver solely

based on an assessment completed through an electronic format.

~~(5)~~ (6) During the UCAT ~~III~~ assessment ~~visit~~, the ~~DHS~~OKDHS nurse informs the applicant of medical eligibility criteria and provides information about the different long-term care service options. ~~When there are multiple household members applying for the ADvantage program, the UCAT assessment is done for them during the same visit.~~ The ~~DHS~~OKDHS nurse documents whether the ~~member~~applicant chooses nursing facility program services or ADvantage program services and makes ~~a level of care~~an LOC and service program recommendation.

~~(6)~~ (7) The ~~DHS~~OKDHS nurse informs the ~~member~~applicant and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the applicant's primary and secondary informed ~~choices,~~provider choice, ensuring adherence to conflict free case management requirements.

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

(B) When the ~~member and/or~~applicant or family declines to make a provider choice, the ~~DHS~~OKDHS nurse documents the decision on ~~Form 02CB001, Member Consents and Rights.~~the consents and rights document.

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

~~(7)~~ (8) The ~~DHS~~OKDHS nurse documents ~~the~~chosen agency names ~~of the chosen agencies~~, or the choiceto decline to select agencies, and the applicant's agreement ~~of the member, by dated signature,~~ to receive waiver services ~~provided by the agencies~~.

~~(8)~~ (9) When the ~~member's~~applicant's needs require an immediate interdisciplinary team (IDT) meeting with the case manager and home health agency nurse participation to develop a person-centered service plan, the ~~DHS~~OKDHS nurse documents the priority procession need ~~for priority processing~~.

~~(9)~~ (10) The ~~DHS~~OKDHS nurse ~~scores the UCAT III. The DHS nurse~~ forwards the completed UCAT ~~III and documentation of financial~~

~~eligibility, documentation of the member's case management and in-home care agency choices~~ to the area nurse or nurse designee for medical eligibility determination.

~~(10)~~(11) When ~~based upon the information obtained during~~the OKDHS nurse determines the UCAT ~~the~~ assessment~~, the DHS nurse determines~~indicates the member ~~may be~~health and safety are at risk~~ for health and safety~~, ~~DHS~~OKDHS Adult Protective Services staff is notified immediately and the referral is documented on the UCAT.

~~(11)~~(12) Within ~~10-business~~ten (10) business days of receipt of a complete ADvantage application, the area nurse or nurse designee determines medical eligibility using nursing facility ~~level of care~~LOC criteria and service eligibility criteria, per OAC 317:35-17-2 and 317:35-17-3, and enters the medical decision on the system.

~~(12)~~(13) Upon SSS financial eligibility notification ~~of financial eligibility from the social service specialist, medical eligibility,~~ and medical eligibility approval for ADvantage entry from the area nurse or nurse designee, ~~the~~ AA communicates with the case management provider to begin care and service plan development. ~~The AA communicates to the case management provider, the member's name, address, case number, Social Security number,~~AA provides the member's demographic and assessment information, and the number of ~~units of~~ case management and ~~the number of units of~~ home care ~~agency~~ nurse evaluation units authorized for service plan development. When the member requires an immediate home visit to develop a person-centered ~~within 24 hours, the~~plan, AA contacts the case management provider directly to confirm availability and request IDT priority~~ electronically sends the new case packet information to the case management provider~~.

~~(13)~~(14) When ~~the~~a member is being discharged from a nursing facility or hospital and transferred home, services ~~must be~~are in place to ensure the member's health and safety~~ of the member upon discharge to the home from the nursing facility or hospital, a~~. The member's chosen case manager ~~from an ADvantage case management provider selected by the member and referred by the AA~~ follows the ADvantage ~~institution~~institutional transition~~,~~ case management procedures for care, and service plan development and implementation.

~~(14)~~(15) A new medical ~~level of care~~LOC determination is required when a member requests any ~~changes~~change in service ~~program,~~setting, from:

(A) State Plan Personal Care (SPPC) services to ADvantage services;

(B) ADvantage to ~~State Plan Personal Care~~SPPC services;

(C) ~~nursing~~Nursing facility to ADvantage services; or

(D) ADvantage to nursing facility services.

~~(15)~~(16) A new medical ~~level of care~~LOC determination is not required when a member requests ADvantage services re-activation ~~of ADvantage services~~ after ~~a short-term stay of 90-calendar~~staying ninety (90) calendar days or less in a nursing facility when the member had previous ADvantage services and the ADvantage certification period has not expired~~.~~ by the date the member is discharged.

~~(16)~~(17) When a UCAT assessment ~~was~~is completed more than ~~90-calendar~~ninety (90) calendar days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

**317:35-17-16. Member annual level of care re-evaluation and annual service plan reauthorization**

(a) The ADvantage case manager reassesses the member's needs annually using the Uniform Comprehensive Assessment Tool (UCAT) ~~Parts I and III~~, then evaluates the member's progress ~~of the member~~ toward person-centered service plan goals and objectives. The ADvantage case manager develops the annual person-centered service plan with the member and interdisciplinary team and submits the person-centered service plan to the ADvantage Administration (AA) for authorization. The ADvantage case manager initiates the UCAT reassessment and ~~development of~~develops the annual person-centered service plan at least forty (40) calendar days, but not more than sixty (60) calendar days, prior to the existing plan's end date~~ of the existing person-centered service plan~~. The ADvantage case manager provides AA the reassessment person-centered service plan ~~packet~~reassessment documents no less than thirty (30) calendar days prior to the existing plan's end date~~ of the existing plan~~. The reassessment ~~person-centered service plan packet includes~~documents include the person-centered service plan, UCAT ~~Parts I and III~~, Nursing Assessment and Monitoring Tool and supporting documentation.

(b) For medical eligibility reassessment, ~~The~~ Oklahoma ~~Department of~~ Human Services ~~(DHS)~~(OKDHS) recertification nurse reviews the UCAT ~~Parts I and III~~the ADvantage case manager submitted~~ by the ADvantage case manager for a level of care redetermination~~. When policy defined criteria for nursing facility ~~level of care~~LOC cannot be determined or justified from available documentation or through direct contact with the ADvantage case manager, the member is referred to the local OKDHS nurse. ~~UCAT Parts I and IIIare completed in the member's home by the DHS nurse. The DHS nurse submits the UCAT evaluation to the area nurse or nurse designee, to make the medical eligibility level of care determination.~~The OKDHS nurse then re-assesses the applicant using the UCAT through an electronic format such as a phone and video conference, unless

there are limiting factors which necessitate a face-to-face assessment.

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

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

(c) When medical eligibility redetermination is not made prior to the current medical eligibility expiration, the existing medical eligibility certification is automatically extended.

(1) For members who are not receiving inpatient~~,~~ acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for a maximum of sixty (60) calendar days from the date of the previous medical eligibility expiration date.

(2) For members who are receiving inpatient~~,~~ acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for thirty (30) calendar days from the facility discharge date, ~~of discharge from the facility~~ or the sixty (60)calendar days from the previous medical eligibility's date~~ of the previous medical eligibility date~~, whichever is longer.

(3) When the medical eligibility redetermination is not made by the applicable extended deadline, the member ~~is determined to~~ no longer ~~meet~~meets medical eligibility. The area nurse or nurse designee updates the system's medical eligibility end date~~ and simultaneously notifies AA electronically~~.

(d) When ~~DHS~~OKDHS determines a member no longer meets medical eligibility~~,~~ to receive waiver services, the:

(1) ~~area~~Area nurse or nurse designee updates the medical eligibility end date~~ and notifies the AA electronically~~;

(2) AA communicates to the member's ADvantage case manager that the member ~~was determined to~~ no longer ~~need~~meets medical eligibility for ADvantage as of the eligibility determination effective date~~ of the eligibility determination~~; and

(3) ADvantage case manager communicates with the member and when requested, assists with access to other services.

**317:35-17-27 Incident reporting**

(a) **Reporting requirement.** Certified ADvantage provider staff should report critical and non-critical incidents involving the health and welfare of ADvantage Waiver members to the Oklahoma Human Services Medicaid Services Unit (MSU).

(b) **Critical incidents.** Critical incidents are events with potential to cause significant risk or serious harm to an ADvantage member's safety or well-being. Critical Incidents Reports (CIR) are completed for:

(1) Suspected maltreatment including abuse, neglect, or exploitation, per Section 10-103 of Title 43A of the Oklahoma Statutes (43A O.S. § 10-103);

(2) Attempted suicide or suicidal ideation exhibition;

(3) Unexpected or questionable death;

(4) Falls or injuries requiring medical attention;

(5) Residence loss due to disaster;

(6) An interruption of needed medical supports;

(7) Lost or missing members;

(8) A medication error requiring medical attention;

(9) Use of physical restraints; or

(10) Allegations related to Personal Care Assistant (PCA) or Personal Service Assistant (PSA).

(c) **Non-critical incidents.** Non-critical incidents are events with potential to cause risk to an ADvantage member's safety and well-being, but do not rise to the critical incident level. Non-critical incidents include:

(1) Falls or injuries that do not require medical attention;

(2) Theft allegations;

(3) Threatening or inappropriate behavior;

(4) Substance abuse or use;

(5) Serious allegations related to a provider agency; and

(6) Law enforcement involvement due to challenging behaviors.

(d) **Incident notification requirements.** The reporting provider documents and submits to MSU incidents included in (b) and (c) of this Section in the electronic system on the CIR document, within one business day of becoming aware of the incident. The reporting provider notifies other persons or entities as required by law or regulation, including:

(1) When a service recipient dies, per OAC 340:100-3-35; and

(2) Investigative authorities immediately in cases of suspected maltreatment, as applicable, including:

(A) Local law enforcement;

(B) The Office of Client Advocacy when the alleged perpetrator is a community service worker, per OAC 340:2-3-33; and

(C) Adult Protective Services when the alleged perpetrator is not a community service worker per 43A O.S. § 10-104.

(e) **Internal Investigation.** The provider completes an internal investigation of all critical incidents, unless directed otherwise by an authorized government entity.

(1) All provider investigative reports are submitted to the MSU within ten (10) working days after the initial CIR is completed.

(2) The provider coordinates internal critical incident investigation and response efforts with governmental investigative authorities as required by law.

(3) Provider supervisory staff run a monthly report from the electronic system to review all critical incidents submitted to the MSU. Doing so ensures proper handling and dispensation occurs, as required by the Centers for Medicare and Medicaid Services.

(f) **Escalated issues.** The Escalated Issues (EI) team reviews all CIR and determines whether the appropriate response occurred. EI coordinates their investigation and response efforts with governmental investigative authorities as required by law. For non-critical incident reports, EI reviews and works with the member, the member's informal support, provider, and others to verify appropriate actions are taken to identify barriers to service, prevent future incidents, and assure continued member health and welfare. Investigation results are communicated to the member, legal guardian, or next of kin as appropriate.