Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to the Oklahoma Health Care Authority (OHCA) Proposed Changes Blog.

OHCA COMMENT DUE DATE: February 17, 2017

The proposed policy is a Permanent Rule. The proposed policy was presented at the November 1, 2016 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on March 9, 2017 and the OHCA Board of Directors on March 23, 2017.

Reference: APA WF 16-25A

SUMMARY:
ADvantage Waiver - The proposed revisions update rules for the Advantage program and related services. The revisions add language to comply with Federal regulations specific to home and community based settings. Rules also clarify compensable services and contract requirements. In addition, rules outline audit procedures for specific providers.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR Part 430, 431 et. Al.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Health Policy

FROM: Carmen Johnson
Health Policy

SUBJECT: Rule Impact Statement
APA WF # 16-25A

A. Brief description of the purpose of the rule:

The proposed revision to Chapter 30 Subchapter 5 amends rules regarding the ADvantage program and services provided by the ADvantage waiver program and adding language for new CMS rules regarding heightened scrutiny of HCB settings. The proposed rules for Chapter 30 Subchapter 5 achieve DHS goals by adding policy for CMS CFR rules regarding Home and Community Based Services (HCBS) and heightened scrutiny for those setting that are not HCB settings, an update on services that are provided by the ADvantage waiver program and deletion of those services no longer available in the program, and clarification on the provider contract processes and those providers that are required to have annual audits and adding Adult Day Health and Assisted Living to the list of providers.

The proposed policy is amended to:

- clarify that providers who do not previously have a contract with Aging Services through the Special Unit on Aging for home delivered meals services or Contracts and Coalitions Adult Day Health contract for adult day health services may obtain an ADvantage contract by meeting the administrative, financial and programmatic components for ADvantage Program certification;
- include the Adult Day Health and Assisted Living providers in the periodic programmatic audit;
- add clarity to the rule by accurately reflecting the required processes for case management, monitoring, and reporting activities for the all Waiver services;
- add clarity to the rule by replacing "plan of care" with the term "person-centered service plan";
- provide language cleanup and update commonly used terms;
- update language that the CD PASS option is now available in every Oklahoma county;
- add language clarifying the minimum of 8 units is equivalent to 2 hours and maximum billing units 28 units is equivalent to 7 hours;
- ensure compliance with Center for Medicare and Medicaid Services (CMS) final rules for Adult Day Health providers regarding Home and Community-Based Services (HCBS) Waiver settings have the necessary contents of request for a waiver;
- clarify maximum billing units per day for skilled nursing services;
- add wording to be consistent with the Physical Therapy Act that a physical therapist may evaluate a member's

rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed 30-calendar days. Any treatment required after the 30-calendar day period requires a prescription from a physician or the physician's assistant of the licensee;

- revoke language referencing speech and language therapy services that are no longer offered in the ADvantage waiver;
- add language to ensure compliance with HCBS final rules for HCBS settings in Assisted Living services providers; the ALC must designate 10 residential units for ADvantage member, Residential units designated for ADvantage may be used for other residents at the assisted living center if there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA;
- add language that sets a minimum amount of units designated to be utilized by an ADvantage member for assisted living services;
- update form submission process; and
- remove reference to Consumer Directed Personal Assistance Services and Supports and Advanced Personal Services Assistants as being documented through the Electronic Visit Verification System (EVV) solely for reimbursement.

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 proposed amendments are individuals receiving DHS Aging Services (AS), ADvantage Waiver services, however these individuals bear no costs associated with the implementation of the rule.

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

The classes of persons who benefit are individuals receiving DHS AS ADvantage Waiver services.

D. A description of the probable economic impact of the proposed

rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no economic impact on individuals who receive DHS AS ADvantage Waiver services.

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 probable cost to DHS includes the cost of printing and distributing the rules, estimated to be less than $20.

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 amendments do not have an impact on any political subdivisions or require their cooperation in enforcing the rules.

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 amendments do not have an adverse effect on small business 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 proposed amendments do not increase compliance costs. There are no less costly or non-regulatory methods or less intrusive methods.

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 amendments clarify the grievance processes for personal care services, thereby increasing program effectiveness positively impacting the health, safety, and well-being of affected persons.

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

If the proposed amendments are not implemented, the rules will continue to not provide clarification of services provided by the ADvantage Waiver.

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

Prepared: December 5, 2016
Modified: January 17, 2017

RULE TEXT

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-761. Eligible providers

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

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

Providers must obtain programmatic certification to be ADvantage Program certified.
(2) The provider financial certification process must verify that the provider uses sound business management practices and has a financially stable business. All providers, except for ~~NF~~nursing facility (NF) ~~Respite,~~respite, ~~Medical Equipment~~medical equipment and ~~Supplies,~~supplies, and ~~Environmental Modification~~environmental modification providers, must obtain financial certification to be ADvantage Program certified.
(3) Providers may fail to gain or may lose ADvantage Program certification due to failure to meet ~~either~~ programmatic or financial standards.
(4) At a minimum, provider financial certification is reevaluated annually.
(5) The Oklahoma Department of Human Services ~~(OKDHS)/Aging Services Division (ASD)~~(DHS) Aging Services (AS) evaluates ~~Adult Day Care~~adult day health and ~~Home Delivered Meal~~home-delivered meal providers for compliance with ADvantage programmatic certification requirements. When an adult day health or home-delivered meal provider does not have a contract with AS the provider must obtain programmatic certification to be ADvantage program certified. For ~~Assisted Living Services~~assisted living services provider programmatic certification, the ADvantage program relies in part upon the Oklahoma State Department of ~~Health/Protective~~Health Protective Health Services for review and verification of provider compliance with ADvantage standards for ~~Assisted Living Services~~assisted living services providers. Providers of ~~Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, CD-PASS, and NF Respite~~medical equipment and supplies, environmental modification, personal emergency response systems, hospice, Consumer-Directed personal Assistance Services and Supports (CD-PASS), and NF respite services do not have a programmatic evaluation after the initial certification.
(6) ~~OKDHS/ASD will~~DHS AS does not authorize a legal guardian for a member or an active ~~Power of Attorney~~power of attorney for a member to be that ~~member's Consumer-Directed Personal Assistance Services and Supports (CD-PASS)~~CD-PASS member's services provider ~~of services~~.
(7) ~~OKDHS/ASD will~~DHS AS may authorize a ~~legally responsible spouse of a member~~member's legally-responsible spouse to be SoonerCare reimbursed ~~under the~~per 1915(c) ADvantage Program as a service provider.

(8) ~~OKDHS/ASD~~DHS AS may authorize a member's legal guardian ~~of a member~~ to be SoonerCare reimbursed ~~under the~~per 1915(c) ADvantage Program as a service provider except as a provider of CD-PASS services. Authorization for ~~either~~a spouse or legal guardian as a provider requires the ~~following~~ criteria in (A) through (D) and monitoring provisions to be met~~:~~.

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

(i) ~~either~~ no other provider is available; or

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

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

(B) The service must:

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

(ii) be necessary to avoid institutionalization;

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

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

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

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

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

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

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

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

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

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

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

(iii) ~~maintain~~maintaining and ~~submit~~submitting time sheets and other required documentation for hours paid; and

(iv) ~~be~~is documented in the person-centered service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all ~~waiver~~Waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The AA ~~will monitor~~monitors through documentation submitted by the ~~Case Manager the following:~~case manager, at least quarterly: expenditures, monthly home visits with member, and the health safety, and welfare status of the individual member.

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

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

(9) Providers of durable medical equipment and supplies must comply with ~~OAC~~Oklahoma Administrative Code 317:30-5-210(2) regarding proof of delivery for items shipped to the member's residence.

(10) ~~The OKDHS Aging Service Division (OKDHS/ASD)~~DHS AS periodically performs a programmatic audit of adult day health, assisted living, ~~Case Management,~~case management, ~~Home Care~~home care ~~(providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services)~~(providers of skilled nursing, personal care, in-home respite and advanced supportive/restorative assistance and therapy services) and CD-PASS providers. If due to a programmatic audit, a provider Plan of Correction is required, the AA ~~stops~~may stop new ~~case~~cases and referrals to the provider until the Plan of Correction ~~has been~~is approved, ~~and~~ implemented~~.~~ and follow-up review occurs. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the ~~OKDHS/ASD,~~DHS AS, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

317:30-5-762. Coverage

Individuals receiving ADvantage Program services must ~~have been~~be determined ~~to be~~ eligible for the program and must have an approved ~~plan of care.~~person-centered service plan. Any ADvantage Program service provided must be listed on the approved ~~plan of care and must be necessary~~person-centered service plan to prevent institutionalization of the member. Waiver services ~~which~~that are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted ~~these~~ services available under the State Plan.

(1) ~~To allow for development of administrative structures and provider capacity to adequately deliver~~ Consumer-Directed Personal Assistance Services and Supports (CD-PASS), ~~availability of CD-PASS is limited to ADvantage Program members that reside in counties that have sufficient provider capacity to offer the CD-PASS service option as determined by OKDHS/ASD.~~services are available to ADvantage Program members in every county.

(2) ADvantage ~~Case Managers within the CD-PASS approved area will~~case managers provide information and materials that explain the CD-PASS service option to ~~their~~ members. The ~~AA~~ ADvantage Administration (AA) provides information and material on CD-PASS to ~~Case Managers~~case managers for distribution to members.

(3) The member may request CD-PASS services from ~~their Case Manager~~his or her case manager or call an ~~AA maintained~~AA-maintained toll-free number to request CD-PASS services.

(4) The AA uses the following criteria to determine an ADvantage member's service eligibility to participate in CD-PASS~~:~~, the:

~~(A) residence in the CD-PASS approved area;~~

~~(B)~~(A) member's health and safety with CD-PASS services can reasonably be assured based on a review of service history records and ~~a~~ review of ~~member~~a member's capacity and readiness to assume ~~Employer~~employer responsibilities under CD-PASS with any one of the following findings as basis to deny a request for CD-PASS due to inability to assure member health and safety~~:~~, when the member:

(i) ~~the member~~ does not have the ability to make decisions about his/her care ~~of~~or service planning and the member's ~~"authorized representative"~~authorized representative is ~~not willing~~unwilling to assume CD-PASS responsibilities~~,~~; or

(ii) ~~the member is not willing~~is unwilling to assume responsibility, or to enlist an ~~"authorized representative"~~authorized representative to assume responsibility, in one or more areas of CD-PASS, such as in service planning~~, or in~~ assuming the role of employer of the ~~PSA~~personal services assistant (PSA) or ~~APSA~~advanced personal services assistant (APSA) provider, ~~or~~ in monitoring and managing health or in preparation for emergency backup~~,~~; or

(iii) ~~the member~~member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an ~~"authorized representative"~~authorized representative with capacity to assist with CD-PASS responsibilities;

~~(C)~~(B) member voluntarily makes an informed choice to receive CD-PASS services. As part of the informed choice decision-making process for CD-PASS, the AA staff or ~~the Case Manager~~case manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of ~~Employer of their Personal Services Assistant.~~employer of his or her PSA or APSA. The orientation and enrollment process ~~will provide~~provides the member with a basic understanding of what ~~will be~~is expected of them under CD-PASS, the supports available to assist them to successfully perform ~~Employer~~employer responsibilities and an overview of the potential risks involved.

(5) The AA uses the following criteria to determine that based upon documentation, a person is no longer allowed to

participate in CD-PASS:

(A) the member does not have the ability to make decisions about ~~his/her~~his or her care or service planning and the member's ~~"authorized representative"~~authorized representative is ~~not willing~~unwilling to assume CD-PASS responsibilities; ~~or~~

(B) the member is ~~not willing~~unwilling to assume responsibility~~,~~ or to enlist an ~~"authorized representative"~~authorized representative to assume responsibility~~,~~ in one or more areas of CD-PASS, such as in service planning~~,~~ or in assuming the role of employer of the PSA or APSA provider, or in monitoring and managing health or in preparation for emergency backup; ~~or~~

(C) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an ~~"authorized representative"~~authorized representative with capacity to assist with CD-PASS responsibilities; ~~or~~

(D) the member abuses or exploits ~~their~~the employee; ~~or~~

(E) the member falsifies time-sheets or other work records; or

(F) the member, even with CM/CDA and Financial Management Services assistance, is unable to operate within ~~their~~his or her Individual Budget Allocation; or

(G) inferior quality of services provided by ~~member/employer's employee, or~~the member's PSA or APSA provider(s), inability of the ~~member/employer's employee~~ PSA or APSA provider(s) to provide the number of service units the member requires~~, jeopardizes~~ jeopardizing the member's health and/or safety.

317:30-5-763. Description of services

Services included in the ADvantage Program are:

(1) **Case management.**

(A) Case management services, regardless of payment source assist a member ~~in gaining~~to gain access to medical, social, educational, or other services~~, regardless of payment source~~ that may benefit ~~the member in maintaining~~him or her to maintain health and safety. Case managers: ~~initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services necessary to prevent institutionalization of the member, as determined through the assessments. Case managers initiate the addition of necessary services or deletion of~~

~~unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay, helps the member transition from institution to home by updating the service plan, and preparing services to start on the date the member is discharged from the institution. Case managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate person-centered planning competency.~~

(i) initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility;

(ii) develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

(iii) initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support;

(iv) monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on

all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) helps the member transition from institution to home by updating the person-centered service plan;

(III) prepares services to start on the date the member is discharged from the institution; and

(IV) must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B)Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency person-centered planning.

~~(B)~~(C) Providers may only claim time for billable case management activities, described as:

(i) any task or function per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training, or authority can perform on behalf of a member; and

(ii) ancillary activities, such as clerical tasks including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

~~(C)~~(D) Case management services are prior authorized and billed per 15-minute unit of service using the rate

associated with the location of residence of the member served.

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

(ii) Very rural/difficult service area rate: ~~Case~~case management services are billed using a very rural/difficult service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than 25 persons per square mile. Exceptions are services to members who reside in Oklahoma ~~Department of Human Services Aging Services(DHS AS)~~DHS AS identified ~~zip~~Zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the standard rate.

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

(2) **Respite.**

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

(B) In-home respite services are billed per 15-minute units of service. Within any one-day period, a minimum of eight units (2 hours) must be provided with a maximum of 28 units (7 hours) provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate when provided in a ~~nursing facility.~~NF. Extended respite must be at least eight hours in duration.

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

(3) **Adult day health (ADH) care.**

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

(B) ~~Adult day health~~ADH care is a 15-minute unit of service. No more than eight hours, 32 units~~,~~ (eight hours) are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ~~Adult day health~~ADH care therapy enhancement is a maximum of one session unit per day of service.

(D) ~~Adult day health personal care enhancement is a maximum of one unit per day of bathing, hair care, or laundry service.~~Meals provided as part of this service do

not constitute a full nutritional regimen. One meal, that contains at least one-third of the current daily dietary recommended intake (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, is provided to those participants who are in the center for four or more hours per day, and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.

(E) Personal care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when as ADvantage Waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry service is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one unit per day of bathing, hair care, or laundry service.

(F) DHS Home and Community-Based Services (HCBS) Waiver settings have qualities defined in federal regulation per Section 441.301 (c)(4) of Title 42 of Code of Federal Regulations [42 CFR § 441.301 (c)(4)] based on the needs of the individual defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;

(II) engage in community life;

(III) control personal resources; and

(IV) receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS Waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:

(I) daily activities;

(II) the physical environment; and

(III) with whom to interact.

(v) The ADH facilitates the member's choice regarding services and supports~~,~~ including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be Home and Community-Based settings per 42 CFR § 441.301(c)(5)(v) include:

(i) ADH centers in a publicly or privately-owned facility providing inpatient treatment;

(ii) ADH centers on the grounds of or adjacent to a public institution;

(iii) ADH centers with the effect of isolating individuals from the broader community of individuals not receiving ADvantage Program or another Medicaid HCBS;

(H) If the ADH is presumed not HCBS, according to 42 CFR § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, OHCA, and CMS. The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications**.

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the health, welfare, and safety of the member or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ~~ADLs,~~Activities of Daily Living (ADLs), or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan are also included. This service excludes any equipment and/or supply items not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the SoonerCare rate ~~if~~when established, to the Medicare rate, or to actual acquisition cost, plus 30 percent. All services must have prior authorization.

(6) **Advanced supportive/restorative assistance**.

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable~~,~~ condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B) Advanced supportive/restorative assistance service is billed per 15-minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the Oklahoma Nursing Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice in the state. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care.

The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either Medicaid or the Medicare Home Health Program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member ~~for whom~~, with additional visits for members with advanced supportive/restorative assistance services ~~are~~ authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation ~~visit~~ report is ~~made~~forwarded to the ADvantage Program case manager in accordance with review schedule determined between the case manager and ~~nurse,~~outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ~~advanced supportive/restorative care~~ADvantage member.

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

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

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

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

(I) prepare a one-week supply of insulin syringes for a person who is blind and has diabetes, who can safely self-inject the medication but cannot fill his or her own syringe. This service includes

monitoring the member's continued ability to self-administer the insulin;

(II) prepare oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

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

(IV) provide nail care for the member with diabetes or member who has circulatory or neurological compromise; and

(V) provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation~~,~~ or for other services within the scope of the Oklahoma Nursing Practice Act, including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan ~~and for performing assessment/evaluations, another~~other procedure ~~code is~~codes may be used to bill for all other authorized nursing services. A maximum of eight units, two hours, per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid

in-home care services for which the provider is certified and contracted.

(8) **Skilled nursing services.**

(A) Skilled nursing services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act and are ordered by a licensed physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by an RN, ~~or an~~ LPN, or LVN under the supervision of a ~~registered nurse,~~an RN, licensed to practice in the state. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per 15-minute units of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **~~Home delivered~~Home-delivered meals.**

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

(B) ~~Home delivered~~Home-delivered meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered

service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

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

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

(11) **Physical therapy services.**

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

and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. Under the Physical Therapy Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed 30-calendar days. Any treatment required after the 30-calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services are ~~billed per 15-minute units of service.~~authorized as ADH care therapy enhancement and are a maximum of one session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication ~~disability~~and swallowing disorders/disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve the use of therapeutic means, such as evaluation, specialized treatment, or development~~,~~ and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes ~~paraprofessional therapy assistant~~Speech Language Pathology Assistant services within the limitations of his or her practice, working under the supervision of the licensed ~~speech and~~

~~language pathologist.~~Speech and Language Pathologist. The regimen includes education and training for informal caregivers to assist with, and/or maintain services when appropriate. The ~~speech and language pathologist~~Speech and Language Pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are ~~billed per 15-minute unit of service.~~authorized as ADH care therapy enhancement and are a maximum of one session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice services.**

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six months or less, and orders hospice care. ADvantage hospice care is authorized for a six-month period~~,~~ and requires physician certification of a terminal illness and orders of hospice care. When the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member 30-calendar days prior to the initial hospice authorization end date, and re-certify that the member has a terminal illness, has six months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of 60-calendar day increments with physician certification that the member has a terminal illness and six months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements to be within total person-centered service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care

for the illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice ~~plan of care~~person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice ~~plan of care~~person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a 12-month period is limited to an amount equivalent to 85 percent of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager ~~are~~is responsible for the development and monitoring of the member's personal care services.

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

(15) **Personal emergency response system.**

(A) Personal emergency response system (PERS) is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all of the service criteria in (i) through (vi). The:

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

(ii) member lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

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

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

(B) PERS services are billed using the appropriate ~~HCPC~~Healthcare Common Procedure Coding (HCPC) procedure code for installation, monthly service, or PERS purchase. All services are prior authorized ~~in accordance with~~per the ADvantage approved service plan.

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

(A) CD-PASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enable a member in need of assistance to reside in ~~their~~his or her home and community of ~~their choosing~~choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring the

employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

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

(ii) is solely responsible to provide instruction and training to the PSA or APSA on tasks and works with the consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

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

(iv) supervises and documents employee work time; and

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

(B) The services the PSA may provide include:

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

(ii) assistance with routine bodily functions~~ that may include:~~, such as:

(I) bathing and personal hygiene;

(II) dressing and grooming; and

(III) eating, including meal preparation and cleanup;

(iii) assistance with home services~~ that may include~~, such as shopping, laundry~~ service~~, cleaning, and seasonal chores;

(iv) companion assistance, ~~that may include~~such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, and may include shopping for food, clothing, or other necessities, or

for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who appropriate, order home health services. APSA includes assistance with health maintenance activities that may include:

(i) routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

(ii) removing external catheters, inspecting skin, and reapplication of same;

(iii) administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas ~~(~~pre-packaged only without contraindicating rectal or intestinal conditions;

(iv) applying medicated ~~(prescription)~~prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;

(v) using a lift for transfers;

(vi) manually assisting with oral medications;

(vii) providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;

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

(ix) using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by ~~DHS AS.~~AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other

financial management tasks and functions including, but not limited to:

(i) processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks on prospective hires for ~~PSAs or APSAs~~PSA or APSA on the member/employer's behalf;

(iv) providing orientation and training regarding employer responsibilities, as well employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member ~~in~~ successfully ~~performing~~perform employer-related functions; and

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

(E) The PSA service is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

(17) **Institutional transition services.**

(A) Institutional transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage Waiver services in his or her home and community.

(B) Transitional case management services are services per ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the health, welfare, and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to

require institutionalization. ~~Advantage~~ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed Waiver and other State plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member transition from institution to home by updating the person-centered service plan, including necessary institutional transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by DHS AS to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institutional transition case management services are prior authorized and billed per 15-minute unit of service using the appropriate ~~HCPC~~Healthcare Common Procedure Coding (HCPC) procedure code and modifier associated with the location of residence of the member served per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish transitional case management services from regular case management services.

(C) Institutional transition services may be authorized and reimbursed per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institutional transition services are provided to the member within 180 calendar-days of discharge from the institution.

(iv) ~~services~~Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institutional transition services but fails to enter the Waiver, any institutional transition services provided are not reimbursable.

(18) **Assisted living services~~.~~ (ALS).**

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

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one or more of the following:

(I) rental unit availability;

(II) the compatibility of the member with other residents;

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

(IV) restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. ~~The number of rental units available to service the ADvantage participants may be altered based upon written request from the provider and acceptance by the ADvantage Administration (AA).~~At minimum, the ALC must designate 10 residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC if there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

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

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the Oklahoma State Department of Health regulations per ~~(OAC 310:663-3-3),~~OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

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

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with 24-hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, will be utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

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

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person, and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs"

in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC is inappropriate ~~if~~when any one or more of the conditions exist.

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

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

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

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

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member and the member's representative, ~~if~~when any, the AA and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must

ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. ~~If~~When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA, giving the member ~~30 calendar days,~~30-calendar days written notice of the ALC's intent to terminate the residency agreement and move the member to an appropriate care provider. The ~~30 calendar day~~30-calendar day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

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

(II) the notice date;

(III) the date notice was given to the member and the member's representative, the ADvantage Case Manager, and the AA;

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

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

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) Physical environment.

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, ~~(lease)~~lease, with the ALC. The member must have the

same responsibilities and protections from eviction as all tenants under the landlord tenant law of the state, county, city, or other designated entity.
(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means ~~that is~~ under the control of the member and that preserves privacy, independence, and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.
(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of 360 square feet.
(V) The ALC must provide a private bathroom for each living unit that must be equipped with one lavatory, one toilet, and one bathtub or shower stall.
(VI) The ALC must provide at a minimum, a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance, a microwave is acceptable.
(VII) The member is responsible for furnishing the rental unit. ~~If~~When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if member supplied furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.
(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per 28 Code of Federal Regulations, Part 36, Appendix A, at no additional cost to the member.

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

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

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed, but may be limited by the ALC to the extent to which a visitor may stay overnight.

(XIII) The ALC must be physically accessible to members.

(ii) Sanitation.

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

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

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

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

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

(iii) Health and Safety.

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

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.
(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the Oklahoma State Department of Health (OSDH).
(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.
(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.
(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.
(VII) The ALC must ensure that fire safety requirements are met.
(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.
(IX) The ALC must adopt safe practices for the preparation and delivery of meals.
(X) The ALC must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.
(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) Staff to resident ratios.
(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, 24 hours a day, and seven days a week, to meet the needs of residents and to carry out all of the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.
(II) The ALC must ensure staffing is sufficient to meet the needs of the ADvantage Program members in accordance with each member's ADvantage person-centered service plan.
(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) Staff training and qualifications.
(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

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

(vi) Staff supervision.

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

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

(vii) Resident rights.

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in Section 1-1918 of Title 63 of the Oklahoma Statutes (O.S. 63-1-1918) amended to include additional rights and the clarification of rights as listed in the ADvantage Member Assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

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

legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

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

(viii) Incident reporting.

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also ~~to be~~ made to Adult Protective Services (APS) and to the ~~Oklahoma State Department of Health (OSDH),~~OSDH, as appropriate, ~~in accordance with the ALC's~~per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC are those defined by OSDH per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting Form.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via ~~facsimile or mail~~electronic submission within one business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. ~~If~~When required, a follow-up report of the incident must be submitted via ~~facsimile or mail~~electronic submission to the member's ADvantage case manager and to the AA. The ~~follow up~~follow-up report must be submitted within ~~five business~~5-business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ~~10 business~~10-business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to ~~DHS Adult Protective Services (APS)~~APS as soon as the person is aware of the situation per O.S. 43A § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at the minimum, include who, what, when, where, and the measures taken to protect the member and resident(s)

during the investigation. The follow-up report must at the minimum, include preliminary information, the extent of the injury or damage, ~~if~~when any, and preliminary investigation findings. The final report at a minimum~~,~~ includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services. The ALC must:

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

(II) ~~The ALC must~~ provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ALS are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage assisted living services for a member is one of three per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, IADLs, and health care needs. The rate level is based on the Universal Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA 90-calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage Case Manager 90-calendar days

before:

(I) voluntary cessation of the ALC's ADvantage contract; or

(II) closure of all or part of the ALC.

(ii) The notice of closure must state:

(I) the proposed ADvantage contract termination date;

(II) the termination reason;

(III) an offer to assist the member secure an alternative placement;

(IV) advise the member or member's representative, and the member's ADvantage case manager on available housing alternatives;

(V) the facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iii) Following the last move of the last ADvantage member, the ALC must provide in writing to the AA:

(I) the effective date of closure based on the discharge date of the last resident;

(II) a list of members transferred or discharged and where they relocated,; and

(III) the plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

317:30-5-764. Reimbursement

(a) Rates for ~~waiver~~Waiver services are set in accordance with the ~~rate setting~~rate-setting process by the State Plan Amendment and Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.

(1) The rate for ~~NF Respite~~Nursing Facility (NF) respite is set equivalent to the rate for routine level of care ~~nursing facility~~NF services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health ~~Care are~~is set equivalent to the rate established by the Oklahoma Department of Human Services (DHS) for ~~the~~ equivalent services provided for the ~~OKDHS~~(DHS) Adult Day Service Program that ~~require~~requires providers ~~having~~have equivalent qualifications~~;~~.

(3) The rate for units of ~~Home-Delivered Meals~~home-delivered meals is are set equivalent to the rate established by the ~~Oklahoma Department of Human Services~~DHS for the equivalent

services provided for the ~~OKDHS~~DHS Home-Delivered Meals Program that require providers having equivalent qualifications~~;~~.

(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate ~~which require~~that requires providers ~~having~~have equivalent qualifications~~;~~.

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(6) ~~CD-PASS~~Consumer-Directed Personal Assistance Services and Supports (CD-PASS) rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about ~~the following:~~the items listed in (A) – (C) of this paragraph.

(A) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The PSA and APSA service unit rates are calculated by the ~~OKDHS/ASD~~DHS Aging Services (AS) during the CD-PASS service eligibility determination process. ~~The OKDHS/ASD~~DHS AS sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care ~~(for PSA)~~(PSA) or Advanced Supportive/Restorative ~~(for APSA)~~(APSA)service ~~rate.~~rates. The allocation of portions of the PSA and/or APSA ~~rate~~rates to cover salary, mandatory taxes, and optional benefits ~~(including Worker's Compensation insurance, if available)~~including Worker's Compensation insurance, when available, is determined individually for each member using the CD-PASS Individualized Budget Allocation (IBA) Expenditure Accounts Determination Process.

(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. ~~If~~When the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the ~~Case Manager,~~case manager, based upon an updated assessment, amends the person-centered service plan to increase CD-PASS service units appropriate to meet

additional member need. ~~The OKDHS/ASD,~~DHS AS, upon favorable review, authorizes the amended person-centered service plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member~~,~~ with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(7) Three per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member ~~ADL/IADL~~Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL) and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 times the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 times the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 times the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by ~~UCAT~~Uniform Comprehensive Assessement Tool, Part III (UCAT III) assessment by the member's ADvantage ~~Case Manager~~case manager employed by a ~~Case Management~~case managment agency~~ that is~~ independent of the Assisted Living Services provider. ADvantage payment is not made for 24-hour skilled care in an ~~Assisted Living Center.~~assisted living center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day ~~care~~health or environmental modifications to a member while receiving ~~Assisted Living Services~~assisted living services since these services are integral to and inherent in the provision of ~~Assisted Living Service.~~assisted living service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage ~~Assisted Living.~~assisted living. Separate payment is not made for ADvantage respite to a member while receiving ~~Assisted Living Services~~assisted living services since by definition ~~Assisted Living~~

~~Services~~assisted living services assume the responsibility for 24-hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage ~~Assisted Living Services~~assisted living services provider is allowed to charge a maximum for room and board that is no more than ~~90%~~90 percent of the ~~SSI~~Supplemental Security Income (SSI) Federal Benefit Rate. ~~If in accordance with~~When, per OAC 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

(7) The maximum total annual reimbursement for a ~~member's Hospice~~member's hospice care within a ~~twelve month~~12-month period is limited to an amount equivalent to ~~85%~~85 percent of the Medicare Hospice Cap payment.

(b) The ~~OKDHS/ASD~~DHS AS approved ADvantage person-centered service plan is the basis for the ~~MMIS~~Medicaid Management Information Systems (MMIS) service prior authorization, ~~specifying:~~specifying the:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) Service time for ~~Personal Care, Case Management, Case Management services for Institution Transitioning, Nursing, Skilled Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance, and Advanced Personal Services Assistance~~personal care, case management services for institution transitioning, nursing, skilled nursing, supportive/restorative assistance, and in-home respite, is documented solely 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. Providers are required to use the ~~IVRA~~EVV system after access to the system is made available by ~~OKDHS.~~DHS. The ~~IVRA~~EVV system provides alternate backup solutions should the automated system be unavailable. In the event of ~~IVRA~~EVV backup system failure, the provider ~~will document~~documents time in accordance with their agency backup plan. The agency's backup ~~procedures~~plans are only permitted when the ~~IVRA~~EVV system is unavailable.

(d) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims ~~that are~~ not supported by service plan

authorization ~~and/or~~and documentation of service provisions ~~will be turned over~~are given to ~~the~~OHCA's Program Integrity Unit for follow-up investigation.