Oklahoma Health Care Authority

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

OHCA COMMENT DUE DATE: January 16, 2018

The proposed policy is a Permanent Rule. The proposed policy was presented at the November 7, 2017 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on January 18, 2018 and the OHCA Board of Directors on February 8, 2018.

Reference: APA WF # 17-24B

SUMMARY:
ADvantage Waiver – The proposed revisions to the ADvantage Waiver include clean-up to remove and update outdated policy in order to align with current business practices. In addition, proposed revisions add new language regarding the Ethics of Care Committee for the ADvantage and State Plan Personal Care program which outlines rules and processes. Proposed revisions clarify rules are in accordance with state laws and regulations.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (F)(1) and (3) of Title 63 of Oklahoma Statutes; Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; 42 CFR Part 430, 431 et. Al.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: Carmen Johnson
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 17-24B

A. Brief description of the purpose of the rule:

Proposed revisions provide updated information regarding the certification and recertification periods of medical eligibility determination and systems that are used by the nurses in communicating with DHS country offices. These revisions will reduce the number of visits by the provider agency for service planning. In addition, new language was added regarding the Ethics of Care Committee for the ADvantage and State Plan Personal Care program to outline rules and processes. Finally, proposed revisions clarify rules are in accordance with federal and state laws and include clean-up to remove and update outdated policy in order to align with current business practices.

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 revisions are Department of Human Services, ADvantage Waiver services and State Plan Personal Care services providers, which bear no costs associated with the implementation of the rules.

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

The classes of persons who benefit are individuals receiving services from DHS.

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 services from DHS.

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:

There are no probable costs associated with the enforcement of this rule.

F. A determination of whether implementation of the proposed rule

will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule does 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 rule does 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 rule will 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 revisions bring the rule into compliance with federal and state laws, 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 rules are implemented, the rules will not be in compliance with federal and state law. The proposed rules are intended to comply with federal and state laws, thereby contributing to the health, safety and well-being of vulnerable Oklahomans.

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

Prepared: November 2, 2017

RULE TEXT

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

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

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

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

(b) ~~OKDHS~~The Oklahoma Department of Human Services (DHS) nurse reviews the ~~ADvantage case manager~~ UCAT Parts I and III submitted by the ADvantage case manager for a level of care redetermination. ~~If~~When policy defined criteria for ~~Nursing Facility~~nursing facility level of care cannot be determined or ~~cannot be~~ justified from available documentation ~~available~~ or ~~via~~through direct contact with the ADvantage case manager, ~~a~~ UCAT Parts I and III ~~is~~are completed in the member's home by the ~~local OKDHS~~DHS nurse. The ~~local OKDHS~~DHS nurse submits the UCAT evaluation to the area nurse~~,~~ or nurse designee, to make the medical eligibility level of care determination.

(c) ~~If~~When medical eligibility redetermination is not made prior to the current medical eligibility expiration, the existing medical eligibility certification is automatically extended ~~until level of care redetermination is established~~. ~~If the member no longer meets medical eligibility the area nurse, or nurse designee, updates the system§s "medical eligibility end date" and simultaneously notifies AA electronically.~~

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

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

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

(d) ~~If OKDHS determines a member no longer meets medical eligibility, the AA communicates to the member's case manager that the member has been determined to no longer meet medical eligibility for ADvantage as of the effective date of the eligibility determination. The case manager communicates with the member and if requested, assists the member to access other services.~~When DHS determines a member no longer meets medical eligibility, to receive waiver services, the:

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

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

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

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

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

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

(b) **Closure due to financial or medical ineligibility**. The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility**. ~~Anytime~~When the local ~~OKDHS~~DHS office determines a member does not meet~~ the~~ financial eligibility criteria, the ~~local OKDHS~~DHS office notifies the~~,~~ area nurse or area nurse designee who closes the member's authorization and notifies the member~~ provider,~~ and AA of financial ineligibility~~.~~by system-generated mail. The AA notifies the member's providers of the decision. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** ~~Any time~~When the ~~local OKDHS~~DHS office is notified ~~through MEDATS~~by the nurse or area nurse designee of a decision that the ~~individual~~member is no longer medically eligible for ADvantage services, the ~~local~~DHS office notifies the ~~individual,~~member and AA ~~and provider~~ of the decision. Refer to Oklahoma Administrative Code (OAC) 317:35-17-16 (d). The AA notifies the member's providers of the decision.

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

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

317:35-17-26. Ethics of Care Committee

The ADvantage Program Ethics of Care Committee (EOCC) reviews members cases when the ADvantage, State Plan Personal Care programs or a provider contracted to provide these services determines that a member's identified needs cannot be met through the provision of the ADvantage program or State Plan Personal Care program and other formal or informal services are not in place or immediately available to meet the members health and safety needs. The EOCC is

a core group of designated representatives from Oklahoma Department of Human Services (DHS) Aging Services and Oklahoma Health Care Authority staff and are experts in State Medicaid programs, specifically ADvantage waiver and State Plan Personal Care, and experienced in addressing member issues as it pertains to policy, program, and service delivery.

(a) EOCC decisions are predicated upon four guiding principles.

(1) **Sustainability of member services.** The overarching concern of EOCC is to ensure that all efforts are made to sustain the member's services when possible. EOCC explores options and renders a decision that maintains member safety while averting the primary issue of concern before the EOCC. This is done while assuring member health and safety as outlined in Oklahoma Administrative Code (OAC) 317:35-17-3 (h) (1-7).

(2) **Cultural competence.** EOCC considers the contextual details of the situation to promote needs and interests of ADvantage members and emphasizes understanding of the member's culture and relevant circumstances.

(3) **Balance and reciprocity.** This assures member health and safety is reliant upon the member's cooperation and that of the member's community network, or informal supports. EOCC evaluates the viability of the member's resources to sustain health and safety independent of Medicaid paid supports when making decisions.

(4) **Education and mitigation.** EOCC uses decision-making processes for determining program appropriateness for cases that are problematic or controversial with respect to being able to meet member needs within program constraints. The decision-making process engages expertise from any area of program function relevant to the case in question when necessary. When the case submitted for review is deemed invalid or lacking sufficient merit for review, EOCC rescinds the review until the case meets the appropriate criteria for review.

(b) EOCC reviews ADvantage and State Plan Personal Care cases, including but not limited to, when:

(1) the member can no longer safely remain in the community;

(2) the member shows a consistent pattern of non-compliance and non-cooperativeness that prevents delivery of the authorized person-centered service plan or care plan;

(3) the provider's and/or DHS staff's safety cannot be assured due to the actions of the member, visitor or another household member;

(4) the services required to meet member needs are beyond the scope of defined waiver or State Plan Personal Care services;

(5) the new ADvantage or State Plan Personal Care members meet financial and medical eligibility for the program, but require review for program appropriateness or community potential;

(6) the previous dis-enrolled ADvantage or State Plan Personal Care members that request re-enrollment into the ADvantage or State Plan Personal Care programs;

(7) the member scheduled for an administrative hearing in which the hearing officer requests EOCC review and input;

(8) members under investigation or review by a federal authority; or

(9) all cases in which administrative review and input are warranted.

(c) ADvantage Consumer Directed Personal Assistance Service and Supports (CD-PASS) service option cases are reviewed for the:

(1) circumstances under review are not addressed by CD-PASS requirements for member eligibility;

(2) a case scenario is not otherwise covered by an established process;

(3) established processes of the CD-PASS program do not allow for an adequate resolution to the issues; or

(4) CD-PASS eligibility impacts ADvantage eligibility, such as:

(A) eligibility is removed but that action may place the member at a greater risk; or

(B) a member and/or their legal agent are removed from CD-PASS services due to allegations of fraudulent or illegal actions that may result in the member's loss of ADvantage eligibility.

(d) EOCC review processes include:

(1) ADvantage Administration (AA) Program Assistant Administrator for Member/Provider Relations department chairs the EOCC. He or she is responsible to appoint qualified representatives to the EOCC committee;

(2) committee members, case representatives, or presenters are required to adhere to Health Insurance Portability and Accountability Act and DHS confidentiality standards and be discreet when reviewing and discussing cases under consideration of all records and information disclosed in carrying out the duties and activities of the committee;

(3) all cases that meet the defined criteria for EOCC review are submitted to AA Member/Provider Relations or Escalated Issues teams for processing and presentation;

(4) the Escalated Issues team formally requests a meeting for EOCC case review and develop a meeting agenda and provide EOCC members with relevant supporting documentation of EOCC review prior to the scheduled meeting;

(5) a quorum (half plus one committee member) is present to make a decision or recommendation on any case presented to the EOCC;

(6) designees are not substituted for EOCC members;

(7) the EOCC Chair is notified in advance when it becomes necessary for other parties to be invited due to their expertise on the subject matter;

(8) case presenters are dismissed after their presentations are complete and the EOCC proceeds to mitigate the case;

(9) upon completion of the committee discussion, the EOCC Chair calls for a vote. A majority vote carries the motion. When a tie ensues the Escalated Issues team Program Manager casts the deciding vote;

(10) a member determined by EOCC to be ineligible for ADvantage or Medicaid State Plan Personal Care program services is notified in writing by DHS of the determination and of his or her right to appeal the decision; and

(11) EOCC maintains all meeting minutes, decisions, court hearings, and Escalated Issues case files indefinitely.