

**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:** February 16, 2018

The proposed policy is a Permanent Rule. The proposed policy was presented at the January 2, 2017 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on March 15, 2018 and the OHCA Board of Directors on March 22, 2018.

**Reference:** APA WF #17-27

**SUMMARY:**

**Medically Fragile Waiver** - The proposed policy revisions to the Medically Fragile Waiver is being requested to provide clean-up to the (Overview, Services and Annual Re-evaluation) sections of existing policy for general clarification and alignment with current waiver operation and language included in the approved waiver; including updating of some acronyms used in existing policy.

**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; Social Security Act § 1915(c)

**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 #17-27

A. Brief description of the purpose of the rule:

The proposed Medically Fragile policy is being revised to include provisions for the Medically Fragile Waiver renewal changes. In addition, new language will provide guidelines on when the Uniform Comprehensive Assessment Tool is required to be updated if submitted after 90 days. In order to align revisions with federal regulation requirements, new Environmental Modifications service guidelines were added in addition to guidelines on how payments are to be submitted for this service. Revisions will also provide new criteria in determining a member's eligibility for Self-Directed services. Finally, proposed revisions include removal of outdated language relating to program medical eligibility and updating obsolete acronyms.

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 case managers and the Oklahoma Health Care Authority clinical nurses, as they will be required to follow new criteria regarding UCAT submission, 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:

Buildings and facilities are obligated to conform to applicable State and local building codes and abide by federal regulation 28 CFR Part 36 Appendix A, which speaks to the Americans with Disabilities Act Accessibility Guidelines. This proposed rule will benefit Medically Fragile Waiver program members who require environmental modifications. By specifications being met members will benefit substantially by equivalent or greater access to and usability of the facility.

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, separate justifications for each fee

change:

There is no probable economic impact of the proposed rule upon any classes of persons or political subdivisions.

- 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 not 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: December 6, 2017

**RULE TEXT**

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS**

**SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES**

**317:50-1-2. Definitions**

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

**"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

- (A) bathing,
- (B) eating,
- (C) dressing,
- (D) grooming,
- (E) transferring (includes getting in and out of a tub, bed to chair, etc.),
- (F) mobility,

- (G) toileting, and
- (H) bowel/bladder control.

**"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the ~~LTC~~Long Term Care Nurse or the ~~AA~~information obtained in the Uniform Comprehensive Assessment Test Tool (UCAT) assessment does not have the capability to think, reason, remember or learn required task for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on ~~MSQ~~mental status questionnaire performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

**"Developmental Disability"** means a severe, chronic disability of an individual that:

- (A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
- (B) is manifested before the individual attains age 22;
- (C) is likely to continue indefinitely;
- (D) results in substantial functional limitations in three or more of the following areas of major life activity:
  - (i) self-care;
  - (ii) receptive and expressive language;
  - (iii) learning;
  - (iv) mobility;
  - (v) self-direction;
  - (vi) capacity for independent living; and
  - (vii) economic self-sufficiency; and
- (E) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

**"IADL"** means the instrumental activities of daily living.

**"Instrumental activities of daily living"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

- (A) shopping,
- (B) cooking,
- (C) cleaning,
- (D) managing money,
- (E) using a telephone,
- (F) doing laundry,
- (G) taking medication, and
- (H) accessing transportation.

**"Intellectual Disability"** means that the person has, as determined by a Preadmission Screening Resident Review level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

**"Level of Care Services"** To be eligible for level of care services, meeting the minimum UCAT Uniform Comprehensive Assessment Test criteria established for SNF skilled nursing facility or hospital level of care demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to adequately and appropriately care for self or communicate needs to others;

(E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid State Plan state plan Services, including Personal Care, if financially eligible.

~~**"Intellectual Disability"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.~~

**"MSQ"** means the mental status questionnaire.

**"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

### 317:50-1-3. Medically Fragile Program overview

(a) The Medically Fragile Waiver program is a Medicaid Home and Community Based Services Waiver used to finance non-institutional long-term care services for a targeted group of physically disabled adults when there is a reasonable expectation that the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require skilled nursing facility or hospital level of care to arrest the deterioration. Medically Fragile Waiver program members must be SoonerCare eligible and must not reside in an institution; room and board licensed residential care facility, ~~or licensed assisted living facility~~. The number of members who may receive Medically Fragile Waiver services is limited.

(1) To receive Medically Fragile Waiver services, individuals must meet the following criteria:

(A) be ~~19~~nineteen (19) years of age or older;

(B) have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following:

(i) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(ii) require frequent time consuming administration of specialized treatments which are medically necessary;

(iii) be dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.

(2) In addition, the individual must meet the following criteria:

(A) meet service eligibility criteria [see OAC 317:50-1-3(d)]; and

(B) meet program eligibility criteria [see OAC 317:50-1-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the ~~OHCA~~Oklahoma Health Care Authority to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to ~~DHS~~Department of Human Services form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized. Services provided through the Medically Fragile Waiver are approved based on medical necessity.

(c) Services provided through the Medically Fragile Waiver are:

- (1) case management;
- (2) institutional transition ~~services;~~ case management;
- (3) respite;
- (4) environmental modifications;
- (5) specialized medical equipment and supplies;
- (6) physical therapy, occupational therapy, respiratory therapy, speech therapy or consultation;
- (7) advanced supportive/restorative assistance;
- (8) skilled nursing;
- (9) home delivered meals;
- (10) hospice care;
- (11) medically necessary prescription drugs within the limits of the waiver;
- (12) ~~Medically Fragile Waiver~~ personal care;
- (13) ~~Personal Emergency Response System~~ personal emergency response system (PERS);
- (14) ~~Self Directed~~ self-directed personal care, respite and advanced supportive/restorative assistance;
- (15) ~~Self Directed Goods and Services~~ self-directed goods and services (SD-GS);
- (16) ~~Transitional Case Management Services;~~ transitional case management; and
- (17) ~~SoonerCare~~ medical services within the scope of the State Plan.

(d) A service eligibility determination is made using the following criteria:

- (1) an open Medically Fragile Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Medically Fragile Waiver slots are filled, the member cannot be certified as eligible for Medically Fragile Waiver services and the member's name is placed on a waiting list for entry as an open slot becomes available. Medically Fragile Waiver slots and corresponding waiting lists, if necessary, are maintained.
- (2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age ~~19~~ nineteen (19) or older with a physical disability and may also ~~have an intellectual disability or a cognitive impairment.~~ be technology dependent.
- (3) the individual does not pose a physical threat to self or others as supported by professional documentation.
- (4) members of the household or persons who routinely visit the household, as supported by professional documentation, do



not pose a threat of harm or injury to the individual or other household visitors.

(e) The Medically Fragile Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

(1) if the individual's needs as identified by ~~UCAT~~Uniform Comprehensive Assessment Test assessment and other professional assessments cannot be met through Medically Fragile Waiver program services, SoonerCare ~~State-Plan~~state plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Medically Fragile Waiver program or SoonerCare ~~State-Plan~~state plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require Medically Fragile Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

(f) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the Medically Fragile Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the ~~Provider~~provider for transitioning the member to other services.

(g) Redetermination of program eligibility can be requested for the following reasons:

(1) if the member fails to comply with the community service plan;

(2) if the member's health and safety cannot be ~~ensured;~~assured;

~~(3) if the member is unable or unwilling to accept the negotiated risk of living in the community; or~~

~~(4)~~(3) as deemed necessary by waiver review staff or the member's case manager.

(h) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of ~~their~~his or her right to appeal the decision.

### **317:50-1-5. Medically Fragile Waiver program medical eligibility determination**

A medical eligibility determination is made for Medically Fragile Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT)—~~III~~ assessment, professional judgment and the determination that the member has unmet care needs that require Medically Fragile Waiver Program, ~~SNF~~skilled nursing facility (SNF) or hospital services to assure member health and safety. Medically Fragile Waiver services are initiated to support the informal care that is being provided in the member's home, or, that based on the UCAT, can be expected to be provided in the member's home upon discharge of the member from a SNF or hospital. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Medically Fragile Waiver service provision will supplement the system within the limitations of Medically Fragile Waiver ~~Program~~program policy.

(1) Categorical relationship must be established for determination of eligibility for Medically Fragile Waiver services. If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by Social Security Administration. A follow-up is required with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.

(2) Community agencies complete the UCAT, Part I and forward the form to the ~~OHCA~~Oklahoma Health Care Authority. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.

(3) The member and family are informed of agencies certified to deliver Medically Fragile Waiver case management and in-home care services in the local area to obtain the member's

primary and secondary informed choices.

(A) If the member and/or family declines to make a provider choice, that decision is documented on the member choice form.

(B) A rotating system is used to select an agency for the member from a list of all local certified case management and in-home care agencies.

(4) The names of the chosen agencies and the agreement (by dated signature) of the member to receive services provided by the agencies are documented.

(5) If the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.

(6) If, based upon the information obtained during the assessment, the nurse determines that the ~~member~~member's health and safety may be at risk ~~for health and safety,~~ DHS Department of Humans Services Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(7) Within ten (10) working days of receipt of a complete ~~Medically Fragile Waiver application,~~ UCAT, medical eligibility is determined using level of care criteria and service eligibility criteria.

(8) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address, and case number ~~and social security number,~~ ~~the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the member require an immediate IDT meeting with home health agency nurse participation and the effective date for member entry into the Medically Fragile Waiver Program.~~

(9) If the member has a current certification and requests a change to Medically Fragile Waiver services, a new UCAT is required. The UCAT is updated when a member requests a change from Medically Fragile Waiver services to Personal Care services. If a member is receiving Medically Fragile Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(10) When a UCAT assessment has been completed more than ~~90~~sixty (60) days prior to submission for determination of a medical decision, the UCAT must be updated to reflect changes

in the medical condition; if submitted after ninety (90) days, a new assessment is required.

**317:50-1-6. Determining financial eligibility for the Medically Fragile Waiver program**

Financial eligibility for Medically Fragile Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to ~~ABD~~Aged Blind and Disabled (ABD) may be served through the Medically Fragile Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the Medically Fragile Waiver Program. In determining income and resources for the individual categorically related to ABD, the ~~"family"~~family includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a ~~TANF~~Temporary Assistance for Needy Families case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in Medically Fragile Waiver ~~Program~~ program services is as follows:

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~OKDHS~~DHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS/DHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives HCBW services, Home and Community Based Services (HCBS), or is institutionalized in a NF or ICF/MR, Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or is ~~65~~sixty-five (65) or over and in a mental health hospital.** For an individual with a spouse who receives ~~HCBW services, HCBS,~~ or is institutionalized in a NF or ~~ICF/MR, ICF/IID,~~ or is ~~65~~sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of ~~HCBW~~HCBS program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a ~~HCBW~~HCBS program, or is institutionalized in a NF or ~~ICF/MR, ICF/IID,~~ or is ~~65~~sixty-five (65) or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of Medically Fragile Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is

to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~OKDHS~~DHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives ~~HCBW~~services, HCBS, or is institutionalized in a NF or ~~ICF/MR~~, ICF/IID or is ~~65~~sixty-five (65) or older and in a mental health hospital to be eligible for the Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in ~~OKDHS~~DHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in a Home and Community Based Waiver Program.** ~~Services program.~~ When only one individual of a couple in their own home is in a ~~HCBW~~HCBS Program, income and resources are determined separately. However, the income and resources of the individual who is not in the ~~HCBW~~HCBS program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is receiving Medically Fragile Waiver program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both

spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the Medically Fragile Waiver program cannot exceed the categorically needy standard in ~~OKDHS~~DHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(6)(B)].

**(B) Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the Medically Fragile Waiver program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving Medically Fragile Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving Medically Fragile program services, ~~OKDHS~~DHS Form 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the Medically Fragile Waiver program (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the

maximum amount of resource value that can be protected for the community spouse, as shown on ~~OKDHS~~DHS form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on ~~OKDHS~~DHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving Medically Fragile Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving Medically Fragile Waiver program services cannot exceed the maximum resource standard for an individual as shown in ~~OKDHS~~DHS form 08AX001E, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the Medically Fragile Waiver



program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for ~~Long-Term~~long-term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within ~~30~~thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

- (I) the community spouse's monthly income allowance;
  - (II) the amount of monthly income otherwise available to the community spouse;
  - (III) determination of the spousal share of resource;
  - (IV) the attribution of resources (amount deemed);
- or
- (V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving Medically Fragile Waiver program services is likely to remain under care for ~~30~~thirty (30) consecutive days. The ~~30-day~~thirty (30) day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the ~~30-day~~thirty (30) day period ends.

(C) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

**(4) Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal

of such assets.

(A) For an institutionalized individual, the look-back date is ~~36~~thirty-six (36) months before the first day the individual is both institutionalized and has applied for SoonerCare. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is ~~60~~sixty (60) months.

(B) For purposes of this paragraph, an ~~"institutionalized"~~institutionalized individual is one who is receiving ~~HCBWHCBS~~ program services.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost (\$2,000) to a private patient in an ~~SNF~~skilled nursing facility or ~~Hospital~~hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse;
- or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

- (i) the title to the individual's home was transferred to:
  - (I) the spouse;
  - (II) the individual's child who is under age ~~21~~twenty-one (21) or is blind or totally disabled as

determined by ~~Social Security~~; the Social Security Administration;

(III) a sibling who has equity interest in the home and resided in the home for at least one (1) year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two (2) years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by the Social Security- Administration. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of ~~65~~-sixty-five (65).

(vii) the denial would result in undue hardship. Such determination should be referred to ~~OKDHS~~-State OfficeDHS for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The

notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.

(K) When assets are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(5) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is ~~60~~sixty (60) months before the first day the individual is both institutionalized and has applied for SoonerCare. However, individuals that have purchased an Oklahoma Long-Term Care Partnership ~~Program~~program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an ~~"institutionalized"~~institutionalized individual is one who is receiving Medically Fragile program services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

- (ii) the date on which the individual is:
  - (I) eligible for medical assistance; and
  - (II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.
- (D) The penalty period:
  - (i) cannot begin until the expiration of any existing period of ineligibility;
  - (ii) will not be interrupted or temporarily suspended once it is imposed;
  - (iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.
- (E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on ~~OKDHS~~DHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.
- (F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:
  - (i) by the individual or such individual's spouse;
  - (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or
  - (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.
- (G) ~~Special Situations.~~Special situations that would apply:
  - (i) ~~Separate Maintenance or Divorce.~~Separate Maintenance or Divorce.
    - (I) There shall be presumed to be a transfer of assets if an applicant or member receives less than

half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) ~~Inheritance from a spouse.~~ **Inheritance from a spouse.**

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child who is under age ~~21~~ twenty-one (21) or is blind or totally disabled as determined by ~~Social Security; or the Social Security Administration;~~ or the Social Security Administration; or

(III) a sibling who has equity interest in the home and resided in the home for at least one (1) year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two (2) years immediately prior to the individual's

institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. ~~"Sole benefit"~~Sole benefit means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. ~~"Sole benefit"~~Sole benefit means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of ~~65~~sixty-five (65).

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services

through the use of the undue hardship exemption.

(II) Such determination should be referred to ~~OKDHS~~DHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an ~~APS~~Adult Protective Services referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be



apportioned between the two (2) institutionalized spouses.  
(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five (5) years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

**317:50-1-9. Member annual level of care re-evaluation and annual re-authorization of service plan**

(a) Annually, the case manager reassesses the member's needs and the service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan for certification along with the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.

(b) At a maximum of every ~~eleven~~ (11) months, the case manager makes a home visit to evaluate the Medically Fragile Waiver member using the UCAT, Uniform Comprehensive Assessment Tool (UCAT), Parts I and III and other information as necessary as part of the annual service plan development process.

(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.

(2) As part of the service plan recertification process, the member is evaluated for the continued need for ~~Skilled Nursing Facility~~ skilled nursing facility or hospital level of care.

(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for ~~60~~ sixty (60) days,

whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's ~~"medical eligibility end date"~~medical eligibility end date is updated in the system. The member's case manager is notified that the member has been determined to no longer meet medical eligibility for Medically Fragile Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of Medically Fragile Waiver services.

**317:50-1-11. Closure or termination of Medically Fragile Waiver services**

(a) **Voluntary closure of Medically Fragile Waiver services.** If the member requests a lower level of care than Medically Fragile Waiver services or if the member agrees that Medically Fragile Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of 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 it is determined that a member does not meet the financial eligibility criteria, the member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** When the member is found to no longer be medically eligible for Medically Fragile Waiver services, the individual and provider are notified of the decision.

(c) **Closure due to other reasons.** Refer to OAC 317:50-1-3(e) - (f).

(d) **Resumption of Medically Fragile Waiver services.** If a member approved for Medically Fragile Waiver services has been without services for less than ~~90~~ninety (90) days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a member decides he/she desires to have his/her services restarted after ~~90~~ninety (90) days, the member must request the services.

### 317:50-1-12. Eligible providers

Medically Fragile Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file with the Medicaid Agency (Oklahoma Health Care Authority).

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

(2) The provider financial certification process verifies that the provider uses sound business management practices and has a financially stable business.

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

(4) At a minimum, provider financial certification is reevaluated annually.

(5) ~~Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, and SNF Respite~~medical equipment and supplies environmental modifications, personal emergency response systems, hospice, and skilled nursing facility respite services do not have a programmatic evaluation after the initial certification.

(6) OHCA may authorize a legally responsible family member (spouse or legal guardian) of an adult member to be SoonerCare reimbursed under the 1915(c) Medically Fragile ~~Program~~program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:

(A) Authorization for a legally responsible family member to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

- (i) either no other provider is available; or
- (ii) available providers are unable to provide necessary care to the member; or
- (iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

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

(ii) be necessary to avoid institutionalization;

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

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

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

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

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

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

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

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

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

(i) not provide more than ~~40~~forty (40) hours of services in a seven (7) day period;

(ii) planned work schedules must be available in advance to the member's ~~Case Manager~~case manager, and variations to the schedule must be noted and supplied two (2) weeks in advance to the ~~Case Manager~~case manager, unless change is due to an emergency;

- (iii) maintain and submit time sheets and other required documentation for hours paid; and
- (iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all ~~Waiver~~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 OHCA will monitor through documentation submitted by the ~~Case Manager~~case manager the following:

- (i) at least quarterly reviews by the ~~Case Manager~~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~~case manager on at least a semi annual basis.

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

(8) As additional providers are certified or if a provider loses certification, the OHCA provides notice to appropriate personnel in counties affected by the certification changes.

### **317:50-1-14. Description of services**

Services included in the Medically Fragile Waiver ~~Program~~program are as follows:

#### **(1) Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish ~~Waiver~~waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services which are necessary to prevent

institutionalization of the member, as determined through 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. If a member requires hospital or skilled 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 and 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~~managers must meet Medically Fragile Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to ~~Self-Direct~~self-direct their services, ~~Case Managers~~case managers are required to receive training and demonstrate knowledge regarding the ~~Self-Directed Services~~self-directed service delivery model.

(B) Providers may only claim time for billable ~~Case Management~~case management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:50-1-15(1)(A) that only a Medically Fragile case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities. Payment is not allowed for written reports or record documentation.

(C) Case Management services are prior authorized and billed per ~~15-minute~~fifteen-minute unit of service using the rate associated with the location of residence of the member served.

(i) ~~Standard Rate~~rate: Case Management services are billed using a ~~Standard~~standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater

than ~~25~~twenty-five (25) persons per square mile.

(ii) ~~Very Rural/Difficult Service Area~~ Rate-rural/difficult service area rate: Case ~~Management~~management services are billed using a ~~Very Rural/Difficult Service Area~~very rural/difficult service rate for billable service activities provided to a member who resides in a county with population density equal to or less than ~~25~~twenty-five (25) persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage ~~County~~county adjacent to metropolitan areas of Tulsa and Washington ~~Counties~~counties. Services to these members are prior authorized and billed using the ~~Standard~~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~~twenty-five (25) persons per square mile, or resides in a county with a population density greater than ~~25~~twenty-five (25) persons per square mile.

(D) ~~Case Managers~~managers providing ~~Case Management~~case management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the OHCA Medically Fragile Waiver ~~Staff~~staff.

(E) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(2) ~~Institutional Transition Case Management~~**transitional case management.**

(A) ~~Institutional Transition Case Management Services~~ Services~~case management services~~ are required by the member's service plan, which 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.

(B) ~~Institutional Transition Case Management~~transitional case management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other ~~State~~state plan

services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Institutional ~~Transition Case Management~~transition case management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the ~~member~~member's transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be 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~~fifteen (15) minute unit service. Within any one-day period, a minimum of eight (8) units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight (8) hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(4) **Environmental Modifications.**

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



(B) All services require prior authorization.

(C) All services shall be provided in accordance with applicable state and local building codes and conform to the Americans with Disabilities Act Accessibility Guidelines 28 Code of Federal Regulations Part 36 Appendix A.

(D) Payment for these services is made on an individual basis following a uniform process approved by the Medicaid agency.

**(5) Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies medical equipment and supplies are devices, controls, or appliances specified in the service plan, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies medical equipment and supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped 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 these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus ~~30%~~ thirty (30) percent or invoice cost plus ~~30%~~ thirty (30) percent, whichever is the lesser of the two. OHCA may establish a fair market price through claims review and analysis.

**(6) Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and

procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per ~~15 minute~~ fifteen (15) minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the service plan.

**(7) Nursing.**

(A) Nursing services are services listed in the service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health ~~Program~~ 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 that they meet the member's needs as specified in the service plan. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

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

(II) the 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 in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a ~~one-week~~ (1) week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing 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) monitoring 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) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per ~~15-minute~~ fifteen (15) minute unit of service. A specific procedure code is used to bill for

assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight (8) units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if 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) Home Delivered Meals.**

(A) Home Delivered Meals provide one (1) meal per day. A 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 (1/3) of the ~~Recommended Daily Allowance~~ recommended daily allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) 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 limited on the member's service plan. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

**(9) Occupational Therapy services.**

(A) Occupational Therapy services are those 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 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 limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

**(10) Physical Therapy services.**

(A) Physical Therapy services are those services that prevent 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 use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold 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. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their 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, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per ~~15-~~fifteen (15) minute units of service. Payment is not

allowed solely for written reports or record documentation.

**(11) Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication 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 use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per ~~15-~~minute~~fifteen~~ (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

**(12) Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written

therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

**(13) Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six (6) months or less to live and orders hospice ~~Care.~~care. Medically Fragile Waiver ~~Hospice Care~~hospice care is authorized for a ~~six months~~six (6) month period and requires a physician certification of a terminal illness and orders of hospice care. If 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 thirty (30) days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of ~~60 days~~sixty (60) days increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total 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 which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has 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 terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs

for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A ~~Hospice~~hospice plan of care must be developed by the hospice team in conjunction with the member's 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 individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any ~~30~~thirty (30) day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile ~~Hospice~~hospice services.

(C) Hospice services are billed per diem of service for days covered by a ~~Hospice~~hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

**(14) ~~Medically Fragile Waiver Personal Care.~~**

(A) ~~Medically Fragile~~ Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a ~~Case Manager~~case manager are responsible for development and monitoring of the member's Personal Care plan.

(C) ~~Medically Fragile~~ Personal Care services are prior authorized and billed per ~~15-minute~~fifteen (15) minute unit of service with units of service limited to the number of units on the approved service plan.

**(15) Personal Emergency Response System.**



(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable ~~"help"~~help button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a ~~"help"~~help button is activated. The response center is staffed by trained professionals. For an Medically Fragile ~~Program~~program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

- (i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;
- (ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
- (iii) demonstrates capability to comprehend the purpose of and activate the PERS;
- (iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;
- (v) 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 service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate ~~HCPC procedure code~~health care procedure codes for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved service plan.

(16) **Prescription drugs.** Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) ~~brand name~~brand-name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three (3) ~~brand name~~brand-name or thirteen (13) total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(17) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community

based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved service plan prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's ~~service~~ eligibility to participate in the Self-Directed ~~Services program~~:option:

(i) ~~residence in the Self Directed services approved area~~; have an existing need for Self-Directed services to prevent institutionalization;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's ~~"authorized representative"~~ authorized representative is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an ~~"authorized representative"~~ authorized representative to assume responsibility, in one (1) or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the 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 Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA 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 for their

Personal Care Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer ~~allowed~~ able to participate in the Self-Directed ~~Services~~ services option:

- (i) the member does not have the ability to make decisions about his/her care or service planning and the member's ~~"authorized representative"~~ authorized representative is not willing to assume Self-Direction responsibilities; or
- (ii) the member is not willing to assume responsibility, or to enlist an ~~"authorized representative"~~ authorized representative to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PCA or ASR service providers, or in monitoring and managing health or in preparation for emergency backup; or
- (iii) 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" with capacity to assist with Self-Direction responsibilities; or
- (iv) the member abuses or exploits their employee; or
- (v) the member falsifies time-sheets or other work records; or
- (vi) the member, even with ~~Case Manager~~ case manager and ~~Financial Management Services~~ financial management services assistance, is unable to operate successfully within their Individual Budget Allocation ~~+~~ (IBA); or
- (vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and

responsibility is documented with dated signatures of the member, the designee and the member's ~~Case Manager~~case manager or the OHCA staff.

(i) A person having guardianship or legal power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

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

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the Respite or PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with ~~State~~state and ~~Federal Labor Law~~federal labor law requirements. The member:

(i) recruits, hires and, as necessary, discharges the PCA and ASR

(ii) provides instruction and training to the PCA or ASR on tasks to be done and works with the ~~Case Manager~~case manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an ASR provider task for the first time, the ASR 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 ASR provider personnel file;

(iii) determines where and how the PCA or ASR works, hours of work, what is to be accomplished and, within ~~Individual Budget Allocation~~IBA 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.

(G) ~~Financial Management Services~~FMS are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. ~~Financial Management Services~~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) employer payroll, 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 PCA or ASR provider;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's ~~Individual Budget Allocation~~ IBA;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PCA or ASR provider;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with ~~Individual Budget Allocation~~ IBA planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's ~~Respite~~ respite or PCA or ASR provider; and

(H) The service of Respite or PCA is billed per ~~15-minute~~ fifteen (15) minute unit of service. The number of units of PCA a member may receive is limited to the number of units approved on the Service Plan.

(I) ASR services are billed per ~~15-minute~~ fifteen (15) minute unit of service. The number of units of ASR a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the ~~Individual Budget Allocation (IBA) Expenditure Accounts Determination~~ IBA expenditure accounts determination process for each member. The ~~IBA Expenditure Accounts Determination~~ expenditure accounts determination process includes consideration and decisions about the following:

(i) The ~~Individual Budget Allocation (IBA) Expenditure Accounts Determination~~ IBA expenditure accounts determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PCA and ASR service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The allocation of portions of the PCA and/or ASR rate to cover salary, mandatory taxes, and optional benefits (including ~~Worker's Compensation~~ worker's compensation insurance, if available) is determined individually for each member using the Self-Directed ~~Services Individualized~~

~~Budget Allocation Expenditure Accounts Determination Process.~~ services IBA expenditure accounts determination process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If 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, the ~~Case Manager,~~ case manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PCA or ASR rate. The member, with assistance from the FMS, reviews and revises the IBA ~~Expenditure Accounts~~ expenditure accounts calculation annually or more often to the extent appropriate and necessary.

**(18) Self-Directed Goods and Services (SD-GS).**

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's service plan.

(B) These goods and services are purchased from the self-directed budget. All goods and services must be approved by the Medically Fragile waiver staff. Documentation must be available upon request.

**(19) ~~Transitional Case Management Services.~~ case management.**

(A) ~~Transitional Case Management Services~~ case management are one-time billable expenses for members who transition from within the community to the Medically Fragile waiver.

(B) ~~Transitional Case Management Services~~ case management must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

(C) ~~Transitional Case Management Services~~ case management assist members that are eligible to receive waiver services in gaining access to needed waiver and other ~~State~~ state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the

services which access is gained.

(D) Transitional ~~Case Management Services~~ case management may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

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