
POLICY TRANSMITTAL NO. 09-62	DATE: DECEMBER 28, 2009
OKLAHOMA HEALTH CARE AUTHORITY/AGING SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:35-15-8.1; 35-15-13.2; and 35-17-14.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

The Oklahoma Department of Human Services/Aging Services Division has requested an amendment to rules that would revise who could be paid to serve as a Personal Care Assistant (PCA) to SoonerCare members approved for State Plan Personal Care services. Current policy allows the OKDHS Director under certain circumstances to approve payment from OKDHS state funds for Personal Care to a legally responsible family member. Those situations include instances when no other PCA is available, available PCAs are unable to provide care to the member, or the needs of the member are so extensive that the legally responsible family member who provides the care is prohibited from working outside the home due to the member's need for care. OKDHS has requested the discontinuance of this exception as a cost saving measure since OKDHS is responsible for paying the entire cost of the PCAs' services for these individuals. Currently, there are ten individuals who will be affected by this revision to policy; these individuals will remain eligible for Personal Care services and efforts are being made to find other non-related PCAs for these individuals.

ADvantage Case Management service rules are revised to allow two extra working days for the ADvantage Administration (the Oklahoma Department of Human Services Aging Services Division) to review and either authorize or deny the service plan or amendment. Currently, rules specify that OKDHS staff has three working days to act on the service plan or amendment submitted by the Case Manager. The OKDHS Aging Services Division has requested the revision to allow two additional days as current policy does not allow sufficient time for a thorough review of the material. Additional revisions add current case management practices and procedures to rules.

Original signed on 12-28-09

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WF # 09-EE (NAP)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following an "OKDHS" number, such as personnel policy at OKDHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates OKDHS as the rulemaking agency; the "2" specifies the Chapter number; and the "1" specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, OKDHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, OKDHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at 405-521-4326.

REMOVE

317:35-15-8.1

317:35-15-13.2

317:35-17-14

INSERT

317:35-15-8.1, pages 1-2, revised 12-1-09

317:35-15-13.2, pages 1-7, revised 12-1-09

317:35-17-4, pages 1-9, revised 12-1-09

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

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

(1) **Payment for Personal Care.** Payment for Personal Care services is generally made for care in the member's "own home".

In addition to an owned or rented home, a rented apartment, room or shelter shared with others is considered to be the member's "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., and/or in any other type of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not a setting that qualifies as the member's "own home" for delivery of Personal Care services through SoonerCare. With prior approval of the OKDHS area nurse, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the care plan.

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

(B) **Reimbursement.** Personal Care services payment on behalf of a member is made according to the type of service and number of units of Personal Care services authorized in the Service Authorization Model (SAM) packet.

(i) The amount paid to Personal Care services providers for each unit of service is according to the established SoonerCare rates for the Personal Care services. Only authorized units contained in each eligible member's individual Service Authorization Model (SAM) packet are eligible for reimbursement. Providers serving more than one Personal Care service member residing in the same residence will assure that the members' Service Authorization Model (SAM) packets combine units in the

most efficient manner possible to meet the needs of all eligible persons in the residence.

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

(2) Issue resolution.

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

(B) When a problem with performance of the Personal Care attendant is identified, agency staff will conduct a counseling conference with the member and/or the attendant as appropriate. Agency staff will counsel the attendant regarding problems with his/her performance.

(3) Persons ineligible to serve as Personal Care Assistants.

Payment from SoonerCare funds for Personal Care services may not be made to an individual who is a legally responsible family member (spouse, legal guardian or parent of a minor child) of the member to whom he/she is providing personal care services.

317:35-15-13.2. Individual Personal Care contractor; billing, training, and problem resolution

While OHCA is the contractor authorized under federal law, the Oklahoma Department of Human Services (OKDHS) initiates initial contracts with qualified individuals for provision of Personal Care services as defined in OAC 317:35-15-2. ■ 1 The contract renewal for the PCA is the responsibility of the Oklahoma Health Care Authority (OHCA).

(1) **Payment for Personal Care.** Payment for Personal Care is generally made for care in the member's own home. A rented apartment, room or shelter shared with others is considered "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., does not constitute a suitable substitute home. Personal Care may not be approved if the member lives in the PCA's home except with the interdisciplinary team's written approval. ■ 2 The potential individual PCA must meet the minimum requirements under (2) of this subsection. With OKDHS area nurse approval, or for ADvantage waiver members, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the service plan. ■ 3

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

(i) The unit amounts paid to individual contractors is according to the established rates. A service plan will be developed for each eligible individual in the home and units of service assigned to meet the needs of each member. The service plans will combine units in the most efficient manner to meet the needs of all eligible persons in the household.

(ii) From the total amounts billed by the individual PCA in (i) of this subparagraph, the OHCA (acting as agent for the member-employer) withholds the appropriate percentage of FICA tax and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To assure that the individual contractor's social security account may be properly credited, it is vital that the individual contractor's

social security number be entered correctly on each claim. In order for the OHCA to withhold FICA tax, the LTC nurse must obtain a signed OHCA Form HCA-66, Authorization for Withholding of FICA Tax in Personal Care, from the member as soon as the area nurse, or designee, has approved Personal Care. A copy of the signed HCA-66 must be in the case record. A signed OHCA-0026, Personal Care Program Individual Contract, must be on file with the OHCA before the individual contractor's first claim can be submitted.

(iii) The contractor payment fee covers all Personal Care services included on the service and care plans developed by the LTC nurse or ADvantage case manager. Payment is made for direct services and care of the eligible member(s) only. The area nurse, or designee, authorizes the number of units of service the member receives each month.

(iv) A member may select more than one individual contractor. This may be necessary as indicated by the service and care plans.

(v) The individual contractor may provide SoonerCare Personal Care services for several households during one week, as long as the daily number of paid service units do not exceed eight per day. The total number of hours per week cannot exceed 40.

(B) Release of wage and/or employment information for individual contractors. Any inquiry received by the local office requesting wage and/or employment information for an individual Personal Care contractor will be forwarded to the OHCA, Claims Resolution.

(2) **Member selection of individual PCA.** Members and/or family members recruit, interview, conduct reference checks, and select the individual to be considered as an individual contractor. An individual contractor applicant must have a background check performed by the Oklahoma State Bureau of Investigation (OSBI).

The results of the background check determine whether a person will be permitted to work as an individual Personal Care contractor. According to Section 1025.2 of Title 56 of the Oklahoma Statutes, before the member employer makes an offer to employ or contract with a SoonerCare Personal Care Assistant applicant to provide Personal Care Services to a person who receives SoonerCare Personal Care Services, the OKDHS LTC nurse, acting for the member, must check the OKDHS Community Services Worker Registry to determine if the name of the applicant seeking employment or contract has been entered. The OKDHS LTC

nurse must also check the Certified Nurse Aid Registry. The OKDHS LTC nurse must affirm that the applicant's name is not contained on either registry. The LTC nurse will notify the OHCA if the applicant is on the registry.

(A) **Persons eligible to serve as individual Personal Care Assistants.** Payment is made for Personal Care Services to an individual who:

- (i) is at least 18 years of age,
- (ii) has no pending notation related to abuse, neglect or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry,
- (iii) is not included on the OKDHS Community Services Worker Registry in accordance with Section 1025.2 of Title 56, of Oklahoma Statutes,
- (iv) has not been convicted of a crime as outlined in Title 63 of Oklahoma Statutes, Sections 1-1950 as determined by an OSBI background check,
- (v) demonstrates the ability to understand and carry out assigned tasks, ■ 4
- (vi) is not a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the member being served,
- (vii) has a verifiable work history and/or personal references, verifiable identification, and
- (viii) meets any additional requirements as outlined in the contract and certification requirements with the Oklahoma Health Care Authority. ■ 5

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

(i) Payment cannot be made to a OKDHS or OHCA employee. Payment cannot be made to an immediate family member of an OKDHS employee who works in the same county without OKDHS/Aging Services Division approval. When a family member relationship exists between an OKDHS LTC nurse and a PCA in the same county, the LTC nurse cannot manage services for a member whose individual provider is a family member of the LTC nurse.

(iii) If it is determined that an employee is interfering in the process of providing Personal Care Services for personal or family benefit, he/she will be subject to

disciplinary action.

(3) **Orientation of the Personal Care Assistant.** When a member selects an individual PCA, the LTC nurse contacts the individual to report to the county office to complete the ODH form 805, Uniform Employment Application for Nurse Aide Staff, and the OKDHS form 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation. This process is the responsibility of the LTC nurse. ■ 6 The PCA can begin work when:

- (A) he/she has been interviewed by the member,
- (B) he/she has been oriented by the LTC nurse,
- (C) he/she has executed a contract (OHCA-0026) with the OHCA,
- (D) the effective service date has been established,
- (E) the Community Service Worker Registry has been checked and the PCA's name is not on the Registry,
- (F) the Oklahoma State Department of Health Nurse Aide Registry has been checked and no notations found, and
- (G) the OSBI background check has been completed.

(4) **Training of Personal Care Assistants.** It is the responsibility of the LTC nurse to make sure for each client, that the PCA has the training needed to carry out the plan of care prior to service initiation.

(5) **Problem resolution related to the performance of the Personal Care Assistant.** When it comes to the attention of the LTC nurse or worker that there is a problem related to the performance of the PCA, a counseling conference is held between the member, LTC nurse and worker. The LTC nurse will counsel the PCA regarding problems with his/her performance. ■ 7 Counseling is considered when the staff believe that counseling will result in improved performance.

(6) **Termination of the PCA Provider Agreement.**

(A) A recommendation for the termination of a PCA's contract is submitted to the OHCA and the services of the PCA are suspended immediately when:

- (i) a PCA's performance is such that his/her continued participation in the program could pose a threat to the health and safety of the member or others; or
- (ii) the PCA failed to comply with the expectations outlined in the PCA Provider Agreement and counseling is not appropriate or has not been effective; or
- (iii) a PCA's name appears on the OKDHS Community Services Worker Registry, even though his/her name may not have appeared on the Registry at the time of application or hiring.

(B) The LTC nurse makes the recommendation for the termination of the PCA to the OHCA Legal Division with a copy to the OKDHS State Office Aging Services Division. When the problem is related to allegations of abuse, neglect, or exploitation, OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, the OHCA, and the Oklahoma State Department of Health are notified by the LTC nurse.

INSTRUCTIONS TO STAFF

1. LTC nurse responsibilities in the provision of Medicaid Personal Care Services.

Determines and documents an individual's competency to meet the needs of each client prior to the initiation of Personal Care Services.

Provides and documents ongoing training to the PCA based upon the needs of the PCA and/or the needs of the client.

Utilizes the plan of care to determine the training needs of the PCA for each client assigned and implements the plan of care that meets the needs of each client.

Reports any PCA suspected of abuse, neglect or exploitation to the DHS Adult Protective Services staff, the Attorney General's Medicaid Unit and the Oklahoma Department of Health Nurse Aide Registry.

Prior to service delivery assignment of the PCA, contacts the Oklahoma State Department of Health Nurse Aide Registry for any pending notation related to the abuse, neglect and/or exploitation of a client by a PCA.

Prior to service delivery assignment of the PCA, contacts the Department of Human Services Community Services Worker Registry created pursuant to Section 1025.3 of Title 56 of the Oklahoma Statutes.

An Oklahoma State Bureau of Investigation (OSBI) background check will be initiated prior to the PCA beginning work.

2. The LTC nurse, with input from the DHS social worker, submits a written request for an exception to the rule for the client receiving Personal Care while living in the PCA's home. Documentation included with the exception request shall include the name and case number of the client, the name and address of the potential PCA, the client's diagnosis, physical condition and care needs and the reason for the request.
3. The LTC nurse or Administrative Agent (AA) nurse submits a written request to the area nurse for an exception to the rule restricting provision of Personal Care to the home setting.

Documentation included with the exception request shall include the name and case number of the client, the client's vocational goal(s) and goal justification, the name of the potential PCA, the client's diagnosis and care needs in the vocational setting, the number of hours of care requested per week in the vocational setting and the vocational setting name and address.

4. An Oklahoma State Bureau of Investigation (OSBI) background check will be initiated prior to the PCA beginning work. The LTC nurse must complete the DHS form ADM-130, Request for Background Check, and submit it to the DHS-DCFS Fingerprint Processing Section. The original copy will be returned to the LTC nurse who will file it in the Personal Care Assistant's file. If the results indicate that the individual PCA may have had a felony charge filed against them, the LTC nurse checks with the county court house indicated for the deposition of the case and notes it on the original copy. If the PCA was convicted, pled guilty, or pled no contest, he/she cannot serve as a PCA.
5. When the client selects the individual to be considered as the Personal Care Assistant, the client notifies the county or the LTC nurse. The LTC nurse makes an appointment for the individual to come to the DHS county office for orientation and determination that the individual meets the minimum qualifications to be a Personal Care Assistant. The PCA may begin work after a contract is executed by the OHCA and a determination of competency to carry out the plan of care is made by the LTC nurse. The LTC nurse notifies the social worker of the service effective date and documents it in the client's case record. The county forwards the original contract to the OHCA, who will be responsible for annual renewal. Once the client selects the PCA, the social worker updates the authorization file.
6. Initial interaction between the LTC nurse and the PCA includes, at a minimum:
 - (A) a determination that the PCA has met the qualifying criteria for Personal Care Service provision and has the knowledge and skill to carry out the assigned task on the plan of care as documented on DHS form AG-24, Documentation of Qualifications to Provide Personal Care Service;
 - (B) discussion of the role and responsibilities of the PCA;

- (C) discussion of the needs of the client and the tasks included on the plan of care, DHS form AG-4, Personal Care Plan;
 - (D) discussion of the employer/employee relationship between the client and PCA;
 - (E) assistance in completing OHCA form OHCA-0026, Personal Care Program Individual Contract;
 - (F) discussion of the method of filing claim for payment and record maintenance;
 - (G) discussion of the date service is to begin, the number of hours, and the days per week;
 - (H) discussion of the use of DHS form AG-5, Personal Care Planning Schedule, and DHS form AG-6, Personal Care Service Plan;
 - (I) FICA information;
 - (J) when and how to contact the LTC nurse and DHS social worker; and
 - (K) how to complete the Individual Personal Care Provider Services Record, DHS form AG-PC-8).
7. A follow-up letter is sent to the PCA stating the reason for counseling and the expected change in performance. Notice is also given that continued problems will result in a recommendation for termination. The LTC nurse sends a copy of the PCA letter to the client and files a copy in the county's PCA file and the client's case record maintained by the nurse.

317:35-17-14. Case management services

(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.

(1) Within one working day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. Within three working days of being assigned an ADvantage member, the case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, AA and OKDHS in the program), and review, update and complete the UCAT assessment, and to discuss service needs and ADvantage service providers. The Case Manager notifies in writing the member's UCAT identified primary physician that the member has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) Within 14 calendar days of the receipt of an ADvantage referral, the case manager completes and submits to the AA an individualized care plan and service plan for the member, signed by the member and the case management supervisor. The case manager completes and submits to the AA the annual reassessment service plan documents no sooner than 60 days before the existing service plan end date but sufficiently in advance of the end date to be received by the AA at least 30 calendar days before the end date of the existing service plan. Within 14 calendar days of receipt of a Service Plan Review Request (SPR) from the AA, the Case Manager provides corrected care plan and service plan documentation. Within five calendar days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the care plan and service plan. The care plan and service plan are based on the member's service needs identified by the UCAT, Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for care plan and service plan development. If in-home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage in-home care provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to

meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The case manager identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review/agreement with the care plan and service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the member signs with a mark. If the member refuses to cooperate in development of the service plan, or, if the member refuses to sign the service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the LTC nurse or AA may identify members that require AA intervention.

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

(B) The AA may implement a service plan without the member's signature if the AA has developed an Addendum to the Rights and Responsibilities Agreement for the member. For these members the presence of a document that "requires" their signature may itself trigger a "conflict". In these circumstances, mental health/behavioral issues may prevent the member from controlling their behavior to act in their own interest. Since the person by virtue of level of care and the IDT assessment, needs ADvantage services to assure their health and safety, the AA may implement the service plan if the AA demonstrates effort to work with and obtain the member's agreement through an individualized Addendum to the Rights and Responsibilities Agreement. Should negotiations not result in agreement with the care plan and service plan, the member may withdraw their request for services or request a fair hearing.

(4) CD-PASS Planning and Supports Coordination.

(A) The ADvantage Case Management provider assigns to the CD-PASS member a Case Manager that has successfully completed

training on CD-PASS, Independent Living Philosophy and Person-Centered Planning. Case Managers that have completed this specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to their CD-PASS service planning and support role in working with CD-PASS members. The CDA/CM educates the member about their rights and responsibilities as well as about community resources, service choices and options available to the member to meet CD-PASS service goals and objectives.

(B) 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 or the AA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the 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.

(C) The CDA/CM provides support to the member in the Person-Centered CD-PASS Planning process. Person-Centered Planning is a process directed by the participant, with assistance as needed from an "authorized representative" or support team. The process supports the member to exercise choice and control and to assume a responsible role in developing, implementing and managing their services and supports. The process is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant and it may enlist assistance from individuals freely chosen by the participant to serve as important contributors. The Person-Centered Planning process enables the participant to identify and access a personalized mix of paid and non-paid services and supports to help him/her achieve personally-defined outcomes in the most inclusive community setting. The focus of Person-Centered Planning is on the individual's development of personal relationships, positive roles in community activities, and self-empowerment skills. Decisions are made and outcomes controlled by the participant. Strengths, preferences and an individualized system of support are identified to assist the individual to achieve

functional and meaningful goals and objectives. Principles of Person-Centered Planning are as follows:

- (i) The person is the center of all planning activities.
- (ii) The member and their representative, or support team, are given the requisite information to assume a controlling role in the development, implementation and management of the member's services.
- (iii) The individual and those who know and care about him or her are the fundamental sources of information and decision-making.
- (iv) The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.
- (v) Person-Centered Planning results in personally-defined outcomes.

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

(E) To the extent the member prefers, the CDA/CM develops assistance to meet member needs using a combination of traditional Personal Care and CD-PASS PSA services. However, the CD-PASS IBA and the PSA unit authorization will be reduced proportional to agency Personal Care service utilization.

(F) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the service plan.

(G) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage service plan or plan amendment to authorize CD-PASS Personal Service Assistance units consistent with this individual plan and notifies existing duplicative Personal Care service providers of the end date for those services.

(H) If the plan requires an APSA to provide assistance with Health Maintenance activities, the CDA/CM works with the

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

(i) If the member's APSA has been providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the PSA, additional documentation of competence is not required;

(ii) If the member and APSA attest that the APSA has been performing the specific Health Maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

(I) The CDA/CM monitors the member's well being and the quality of supports and services and assists the member in revising the PSA services plan as needed. 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 to meet needs, the CDA/CM, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional member's need and forwards the plan amendment to the AA for authorization and update of the member's IBA.

(J) The CDA/CM uses the ADvantage Risk Management process the results of which are binding on all parties to resolve service planning or service delivery disagreements between members and ADvantage service providers under the following circumstances:

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

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

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

(K) The CDA/CM and the member prepare an emergency backup/emergency response capability for CD-PASS PSA services in the event a PSA provider of services essential to the

individual's health and welfare fails to deliver services. As part of the planning process, the CDA/CM and member define what failure of service or neglect of service tasks would constitute a risk to health and welfare to trigger implementation of the emergency backup. Any of the following may be used in planning for the backup:

(i) Identification of a qualified substitute provider of PSA services and preparation for their quick response to provide backup services when called upon in emergency circumstances (including execution of all qualifying background checks, training and employment processes); and/or,

(ii) Identification of one or more qualified substitute ADvantage agency service providers (Adult Day Care, Personal Care or Nursing Facility Respite provider) and preparation for their quick response to provide backup services when called upon in emergency circumstances.

(L) If the emergency backup fails, the CDA/CM is to request the AA to authorize and facilitate member access to Adult Day Care, Agency Personal Care or Nursing Facility Respite services.

(5) The case manager submits the care plan and service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within two working days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected care plan and service plan to the case management supervisor within two working days. The case management supervisor returns the approved care plan and service plan to the case manager. Within one working day of receiving supervisory approval, the case manager forwards, via postal mail, a legible copy of the care plan and service plan to the AA. Case managers are responsible for retaining all original documents for the member's file at the agency. Only priority service needs and supporting documentation may be faxed to the AA with the word, "PRIORITY" being clearly indicated and the justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the nursing facility. Corrections to service conditions set by the AA are not considered to be a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a nursing facility.

(6) Within one working day of notification of care plan and service plan authorization, the case manager communicates with the service plan providers and with the member to facilitate service plan implementation. Within one working day of receipt of a copy of the computer-generated authorized service plan from the AA, the case manager sends (by mail or fax) copies of the authorized service plan or computer-generated copies to providers. Within five working days of notification of an initial or new service plan authorization, the case manager visits the member, gives the member a copy of the service plan or computer-generated copy of the service plan and evaluates the progress of the service plan implementation. The case manager evaluates service plan implementation on the following minimum schedule:

- (A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and
- (B) monthly after the initial 30 day follow-up evaluation date.

(b) Authorization of service plans and amendments to service plans.

The ADvantage Administration (AA) certifies the individual service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, plan cost effectiveness, that service providers are ADvantage authorized and SoonerCare contracted, and that the delivery of ADvantage services are consistent with the member's level of care need, the service plan is authorized. Except as provided by the process described in OAC 317:30-5-761(6), family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member (spouse or parent of a minor child).

- (1) If the service plan authorization or amendment request packet received from case management is complete and the service plan is within cost effectiveness guidelines, the AA authorizes or denies authorization within five working days of receipt of the request. If the service plan authorization or amendment request packet received from case management is complete and the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the member to access services in an alternate setting or program. If the request packet is not complete, the AA notifies the case manager immediately and puts a "hold" on authorization until the required additional documents are received from case management.
- (2) The AA authorizes the service plan by entering the authorization date and signing the submitted service plan.

Notice of authorization and a copy of the authorized plan or a computer-generated copy of the authorized plan are provided to case management. AA authorization determinations are provided to case management within one working day of the certification date. A service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval.

(3) For audit purposes (including SURS reviews), the computer-generated copy of the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. State or Federal quality review and audit officials may obtain a copy of specific service plans with original signatures by submitting a request to the AA.

(c) **Change in service plan.** The process for initiating a change in the service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the member's service plan. The requested changes and justification for them are documented by the service provider and, if initiated by a direct care provider, submitted to the member's case manager. If in agreement, the case manager requests the service changes on a care plan and service plan amendment submitted to the AA within five calendar days of assessed need. The AA approves or denies the care plan and service plan changes within five calendar days of receipt of the plan.

(2) The member initiates the process for replacing Personal Care services with Consumer-Directed Personal Services and Supports (CD-PASS) in geographic areas in which CD-PASS services are available. The member may contact the AA using a CD-PASS services request form provided by the Case Manager or by calling the toll-free number established to process requests for CD-PASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour or more adjustment in services per week, requires a UCAT reassessment by the case manager. The case manager, in consultation with AA, makes the determination of need for reassessment. Based on the reassessment and consultation with the AA, the member may, as appropriate, be authorized for a new service plan or be eligible for a different service program. If the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated

signature indicating voluntary withdrawal for ADvantage program services. If unable to obtain the member's consent for voluntary closure, the case manager requests assistance from the AA. The AA requests that the OKDHS area nurse initiate a reconsideration of level of care. If the member's service needs are different or have significantly increased, the case manager develops an amended or new service plan and care plan, as appropriate, and submits the new/amended plans for authorization.