
POLICY TRANSMITTAL NO. 05-47	DATE: OCTOBER 11, 2005
AGING SERVICES DIVISION/OKLAHOMA HEALTH CARE AUTHORITY	DEPARTMENT OF HUMAN SERVICES OFFICE OF PLANNING, POLICY & RESEARCH

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-761 through 30-5-763; 30-5-764; 35-17-3; and 35-17-14.

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

Rules are revised to implement a Consumer-Directed Personal Assistance Services and Supports (CD-PASS) service option in the ADvantage Waiver Program. CD-PASS is a voluntary pilot project in the Tulsa area which will offer some clients an option of directing their personal care services with assistance from an Employee Support Services Provider. Clients who elect to participate will be the provider's "employer of record" and will employ, train, discharge and schedule their personal care assistant, instead of utilizing a licensed home care agency. Support assistance provided to the client will include payroll functions (including appropriate withholding), technical assistance, and consultation.

ADvantage Waiver Services rules are also revised to establish Institution Transition Services as a separate billable service under Medicaid for individuals who qualify for ADvantage Program services. Institution Transition Services are those services that are necessary to enable an individual to leave an institution and receive necessary support in their own home. These services may include Case Management, Nursing Assessment and evaluation for in-home service planning, Environmental Modifications and Medical Equipment and Supplies.

Original signed on 10-10-05

Carey Garland, Interim Director
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WF # 05-Y (DT)

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 a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS 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, DHS 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, DHS: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) 521-3611.

REMOVE

INSERT

317:30-5-761	317:30-5-761, pages 1-4, revised 5-4-05
317:30-5-762	317:30-5-762, pages 1-3, revised 5-4-05
317:30-5-763	317:30-5-763, pages 1-21 revised 7-01-05
317:30-5-764	317:30-5-764, pages 1-4, revised 5-4-05
317:35-17-3	317:35-17-3, pages 1-5, revised 7-01-05
317:35-17-14	317:35-17-14, pages 1-9, revised 5-4-05

**MEDICAL PROVIDERS - FEE FOR SERVICE
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OAC 317:30-5-761 (p1)

317:30-5-761. Eligible providers

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

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

(2) The provider financial certification process shall verify that the provider uses sound business management practices and has a financially stable business. All providers, except for NF Respite, Medical Equipment and Supplies, and Environmental Modification providers, must obtain financial certification to be ADvantage Program certified.

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

(4) At a minimum, the AA reevaluates provider financial certification annually.

(5) The AA relies upon DHS/Aging Services Division (ASD) for ongoing programmatic evaluation of Adult Day Care and Home Delivered Meal providers for continued programmatic certification. Providers of Medical Equipment and Supplies, Environmental Modifications, and NF Respite services do not have a programmatic evaluation after the initial certification.

(6) For a legally responsible spouse or legal guardian of an adult client to be Medicaid reimbursed under the 1915(c) ADvantage Program as a service provider, the provider must meet all of the following authorization criteria and monitoring provisions:

(A) Authorization for a spouse or legal guardian to be

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the care provider for a client may occur only under the following conditions:

(i) The client 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 client; or

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

(ii) The Director of OKDHS approves a request for spouse or legal guardian to be the provider under one of the aforementioned documented circumstances.

(B) The service must:

(i) meet the definition of a service/support as outlined in the federally approved 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 State Medicaid Agency 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

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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 client; or

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

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

(IV) spouse or guardian provides assistance/care for the client thirty-five or more hours per week without pay and the client 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 client.

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

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

(ii) planned work schedules must be available two weeks in advance, and variations to the schedule must be noted and supplied to the fiscal agent when billing;

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

(iv) be documented in the service plan as the client's care provider.

(D) In addition to case management, monitoring, and

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reporting activities required for all waiver services, the state is obligated to the following additional monitoring requirements when clients elect to use a spouse or legal guardian as a paid service provider:

(i) at least quarterly reviews by the AA of expenditures and the health, safety, and welfare status of the individual recipient;

(ii) face-to-face visits with the recipient by AA representative on at least a semi annual basis; and

(iii) monthly reviews by the AA of hours billed for spouse or legal guardian providing care.

(7) The AA or OKDHS Aging Service Division (OKDHS/ASD) 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), Comprehensive Home Care, and CD-PASS providers. If due to a programmatic audit, a provider Plan of Correction is required, the AA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the AA and OKDHS/ASD, clients determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

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317:30-5-762. Coverage

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

(1) To allow for development of administrative structures and provider capacity to adequately deliver Consumer-Directed Personal Assistance Services and Supports (CD-PASS), availability of CD-PASS is limited to ADvantage Program clients that reside in the following counties and zip codes:

(A) Tulsa;

(B) Creek;

(C) Rogers;

(D) Wagoner; and

(E) Osage County zip codes of 74126, 74127, 74106, and 74063.

(2) ADvantage Case Managers within the CD-PASS geographic target area will provide information and materials that explain the CD-PASS service option to their clients. The AA provides information and material on CD-PASS to Case Managers for distribution to clients.

(3) The client may request CD-PASS services from their Case Manager or call an AA maintained toll-free number to request CD-PASS services.

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

(A) residence in the CD-PASS geographic target area;

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(B) client's receipt of State Plan or ADvantage Personal Care services for 12 months or more;

(C) client's health and safety with CD-PASS services can reasonable be assured based on a review of service history records and a review of client capacity and readiness to assume Employer responsibilities under CD-PASS with any one of the following findings as basis to deny a request for CD-PASS due to inability to assure client health and safety;

(i) the client does not have the ability to make decisions about his/her care of service planning and the client's Aauthorized representative@ is not willing to assume CD-PASS responsibilities, or

(ii) the client is not willing to assume responsibility, or to enlist and Aauthorized representative@ to assume responsibility, in one or more areas of CD-PASS such as in service planning, or in assuming the role of employer of the PSA or APSA provider, or in monitoring and managing health or in preparation for emergency backup, or

(iii) the client 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 Aauthorized representative@ with capacity to assist with CD-PASS responsibilities;

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

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(5) The AA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in CD-PASS:

(A) the client does not have the ability to make decisions about his/her care or service planning the client's Aauthorized representative@ is not willing to assume CD-PASS responsibilities; or

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

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

(D) participant abuses or exploits their employee; or

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

(F) based on documented experience of being abusive and/or uncooperative, no Employer Support Services Provider will agree to assist the person, or

(G) participant, even with Employer Support Services Provider assistance, is unable to operate within their Individual Budget Allocation; or

(H) inferior quality of services provided by participant's employee jeopardizes the participant's health and/or safety.

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) Case Management.

(A) Case Management services are services that assist a client in gaining access to medical, social educational or other services, regardless of payment source of services, that may benefit the client in maintaining health and safety.

Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the client's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the client, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the client's condition and available support. Case managers monitor the client's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a client requires hospital or nursing facility services, the case manager assists the client in accessing institutional care and, as appropriate, periodically monitors the client's progress during the institutional stay and helps the client transition from institution to home by updating the service plan and preparing services to start on the date the client is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage clients. Prior to providing services to clients receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

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

(i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a client;

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(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;

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

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

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a client who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to clients that reside in AA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these clients are prior authorized and billed using the Standard rate.

(iii) The United States 2000 Census, Oklahoma Counties population data is the source for determination of whether a client resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) Respite.

(A) Respite services are provided to clients 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 hours are

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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 plan of care when it is necessary to prevent institutionalization of the client. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the client'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 hours in duration.

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

(3) Adult Day Health Care.

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week, at least four hours per day in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the client. Physical, occupational, respiratory and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service shall not constitute a full nutritional regimen. Transportation between the client's residence and the service setting is provided as a part of Adult Day Health Care. Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing and/or hair washing will be authorized when an ADvantage waiver client

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who uses adult day health care requires assistance with bathing and/or hair washing to maintain health and safety.

(B) Adult Day Health Care is a 15 minute unit. No more than 6 hours are authorized per day. The number of units of service a client may receive is limited to the number of units approved on the client's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

(4) Environmental Modifications.

(A) Environmental Modifications are physical adaptations to the home, required by the client's plan of care, 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 client would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client are excluded.

(B) All services require prior authorization.

(5) Specialized Medical Equipment and Supplies.

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable clients 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 shall exclude any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver client. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. All services

must be prior authorized.

(6) **Comprehensive Home Care.** Comprehensive Home Care is an integrated service-delivery package which includes case management, personal care, skilled nursing, in-home respite and advanced supportive/restorative assistance.

(A) Comprehensive Home Care is provided by an agency which has been trained and certified by the Long Term Care Authority to provide an integrated service delivery system. Comprehensive Home Care is case management in combination with one or more of the following services:

- (i) personal care,
- (ii) in-home respite,
- (iii) skilled nursing, and/or
- (iv) advanced supportive/restorative services.

(B) All services must be provided in the home and must be sufficient to achieve, maintain or improve the client's ability to carry out daily living activities. However, with OKDHS area nurse approval, or for ADvantage waiver clients, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the client in achieving vocational goals identified on the service plan. The sub-component services of Comprehensive Home Care are the same as described in (A) of this paragraph (see subparagraph (1)(A) of this section for Case Management services, OAC 317:35-15-2 for Personal Care service, subparagraph (8)(A) of this section for Skilled Nursing, subparagraph (2)(A) of this section for In-Home Respite, and subparagraph (7)(A) of this section for Advanced Supportive/Restorative Assistance).

(C) CHC services are billed using the appropriate HCPC procedure code along with the CHC provider location code on the claim.

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

(A) Advanced Supportive/Restorative Assistance services are

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maintenance services to assist a client who has a chronic, yet stable, condition. The service assists 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 unit of service. The number of units of this service a client may receive is limited to the number of units approved on the plan of care.

(8) Skilled Nursing.

(A) Skilled Nursing services are services of a maintenance or preventive nature provided to clients with stable, chronic conditions. These services are not intended to be treatment for an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide, assessment of the client's health and assessment of services to meet the client's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each client for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the client. A monthly visit report will be made to the ADvantage Program case manager, to report the client's condition or other significant information concerning each advanced supportive/restorative care client.

(i) The ADvantage Program case manager may recommend authorization of Skilled Nursing services for assessment/evaluation of:

(I) the client'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 client'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

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as established by the Oklahoma Board of Nursing.

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

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

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

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

(IV) providing nail care for the diabetic client or client with circulatory or neurological deficiency;

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

(B) Skilled Nursing service is billed for an assessment/evaluation per assessment or, for non-assessment services, billed for the first hour unit of service and for each 15-minute unit of service provided after the first hour.

An agreement by a provider to produce a nurse evaluation is an agreement, as well, to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation shall be denied if the provider that

produced the nurse evaluation fails to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted.

(9) Home Delivered Meals.

(A) Home Delivered Meals provide one meal per day brought to the client's home. Each meal has a nutritional content equal to one third of the Recommended Daily Allowance. Meals are only provided to clients who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal/unit. The limit of the number of units a client is allowed to receive is limited on the client's plan of care.

(10) 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 clients with physical disabilities and related psychological and cognitive impairments. Services are provided in the client's home and are intended to help the client 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 client to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the client'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 client's rehabilitative progress and will report to the client's case manager and physician to coordinate necessary addition and/or deletion of services, based on the client's condition and ongoing rehabilitation potential.

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

(11) Physical Therapy services.

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of clients disabled by pain, disease or injury. Services are provided in the client's home and are intended to help the client 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 client'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 client's rehabilitative progress and will report to the client's case manager and physician to coordinate necessary addition and/or deletion of services, based on the client's condition and ongoing rehabilitation potential.

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

(12) Comprehensive Home Care (CHC) Personal Care.

(A) Comprehensive Home Care (CHC) Personal Care is assistance to a client 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 client 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

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irrigation, and operation/maintenance of equipment of a technical nature.

(B) CHC Case Manager and Skilled Nursing staff are responsible for development and monitoring of the client's CHC Personal Care plan.

(C) Comprehensive Home Care (CHC) Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

(13) 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 clients disabled by pain, disease or injury. Services are provided in the client's home and are intended to help the client 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 therapist evaluates the client'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 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 client's rehabilitative progress and will report to the client's case manager and physician to coordinate necessary addition and/or deletion of services, based on the client's condition and ongoing rehabilitation potential.

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

(14) Respiratory Therapy Services.

(A) Respiratory therapy services are provided for a client

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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 client'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 client. Treatment involved 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 client 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 client's progress and will report to the client's case manager and physician to coordinate necessary addition and/or deletion of services, based on the client's condition and ongoing rehabilitation potential.

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

(15) Hospice Services.

(A) Hospice is palliative and/or comfort care provided to the client and his/her family when a physician certifies that the client has a terminal illness and has six months or less to live and orders Hospice Care. 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 client signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the client's illness. Once the client has elected hospice care, the hospice medical team assumes responsibility for the client'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

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services, dietary counseling and grief and bereavement counseling to the client and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the client's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the client's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ADvantage Hospice may be provided to the client in a Nursing Facility (NF) only when the client is placed in the NF for ADvantage 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 day period. A client that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

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

(16) ADvantage Personal Care.

(A) ADvantage Personal Care is assistance to an individual 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) ADvantage Home Care Agency Skilled Nursing staff working in coordination with an ADvantage Case Manager are responsible for development and monitoring of the client's Personal Care plan.

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

of care.

(17) 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" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with client preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program client to be eligible to receive PERS service, the client 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 client'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 client's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the client.

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

(18) Consumer-Directed Personal Assistance Services and Support (CD-PASS).

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance, Advanced Personal Services Assistance and Employer Support Services that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The client employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Employer Support Services provider, for ensuring that the employment complies with State and Federal Labor Law requirements. The client may designate an adult family member or friend, an individual who is not a PSA or APSA to the client, as an Authorized representative to assist in executing these employer functions. The client:

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

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain Advantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the SPSA must demonstrate competency in the tasks in an on-the-job training session conducted by the client and the client must document the attendant's competency in performing each task in the ASPA's personnel file;

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

(iv) supervises and documents employee work time; and,

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

(B) The service Personal Services Assistance may include:

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

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming;

(III) eating including meal preparation and cleanup;

(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;

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

(C) Advanced Personal Services Assistance are maintenance services provided to assist a client with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Clients who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance

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with health maintenance activities that may include:

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

(ii) remove external catheters, inspect skin and reapplication of same;

(iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with clients without contraindicating rectal or intestinal conditions;

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

(v) use lift for transfers;

(vi) manually assist with oral medications;

(vii) provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;

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

(ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Employer Support Services is assistance with employer related cognitive tasks, decision-making and specialized skills that may include:

(i) assistance with Individual Budget Allocation planning and support for making decisions, including training, reference material and consultation, regarding employee management tasks such as recruiting, hiring, training and supervising the Personal Service Assistant or Advanced Personal Service Assistant;

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(ii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the client, on prospective hires for PSAs or APSAs;

(iii) for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards;

(iv) for performing 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 mandatory withholding for taxes, Unemployment Insurance and Workers' Compensation Insurance performed on behalf of the client as employer of the PSA or APSA; and

(II) other employer related payment disbursements as agreed to with the client and in accordance with the client's Individual Budget Allocation.

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a client may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a client may receive is limited to the number of units approved on the Service Plan.

(G) The service of Employer Support Services is billed per month unit of service. The Level of service and number of units of Employer Support Services a client may receive is limited to the Level and number of units approved on the Service Plan.

(19) Institution Transition Services.

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADVantage

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waiver services in their home and/or in the community. Institution Transition Services may include, as necessary, any one or a combination of the following:

(i) Case Management;

(ii) Nursing Assessment and Evaluation for in-home service planning;

(iii) Environmental Modifications including Assessment for Transition Environmental Modification Services; and/or,

(iv) Medical Equipment and Supplies.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Advantage Transition Case Management Services assist institutionalized individuals that are eligible to receive Advantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an Advantage client's progress during an institutional stay, and for assisting the client transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the client is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received Advantage services but have been referred by the AA or OKDHS to the Case Management Provider for assistance in transitioning from the institution to the community with Advantage services support.

(i) Institution Transition Case Management services are prior authorized and billed per 15 minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the client served as

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described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institution Transition Skilled Nursing Services are nursing services, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Institutional Transition Skilled Nursing services are solely for assessment/evaluation and service planning for in-home assistance services.

(i) Institution Transition Skilled Nursing services are prior authorized and billed per assessment/evaluation visit using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Skilled Nursing Services from regular Skilled Nursing Services.

(D) Institution Transition Environmental Modifications are those physical adaptations to the home, required by the individual's plan of care, 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 individual would continue to require institutionalization. Such adaptations are the same as described under OAC 317:30-5-763(4)(A) and may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Services may

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include accessibility evaluation of the client's home and follow-up evaluation of the adequacy of installed environmental modifications to meet the client's accessibility and environmental adaptive needs. Accessibility evaluation services must be performed by an Accessibility Specialist who is trained and certified through a Federal or State agency approved program for Americans with Disabilities Act (ADA) Accessibility Guidelines - Title III (Public Accommodations) or by a physical or occupational therapist. Accessibility evaluation services do not include evaluations of the need for modifications or equipment that serve a therapeutic or rehabilitative function for which a therapist evaluation is necessary.

(i) Institution Transition Environmental Modification services are prior authorized and billed using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Environmental Modification Services and Assessments from regular Environmental Modification Services and Assessments.

(E) Institution Transition Specialized medical equipment and supplies are those devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, 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 individual would continue to require institutionalization. This service also includes 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. Item reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

(i) Institution Transition Medical Equipment and Supply

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services are prior authorized and billed using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Medical Equipment and Supply Services from regular Medical Equipment and Supply services.

(F) Institutional Transition Services may be authorized and reimbursed under the following conditions:

(i) The service is necessary to enable the individual to move from the institution to their home;

(ii) The individual is eligible to receive ADvantage services outside the institutional setting;

(iii) Institutional Transition Services are provided to the individual within 120 days of discharge from the institution;

(iv) Transition Services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(G) If the client has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services authorized and provided are reimbursed as "Medicaid administrative" costs and providers follow special procedures specified by the AA to bill for services provided.

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317:30-5-764. Reimbursement

(a) Rates for waiver services are set in accordance with the rate setting process by the Committee for Rates and Standards and approved by the Oklahoma Health Care Authority Board.

(1) The rate for NF Respite is set equivalent to the rate for enhanced nursing facility services that require providers having equivalent qualifications;

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

(3) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications;

(4) The rates for units of In-Home Respite, CHC Personal Care, and CHC In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;

(5) The rates for a unit of Skilled Nursing and CHC Skilled Nursing are set equivalent to State Plan Home Health Benefit Skilled Nursing unit that require providers having equivalent qualifications.

(6) CD-PASS rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each client. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(A) Authorized PSA and APSA units (determined from CDA/CM and client planning);

(B) Total CD-PASS IBA (annualized authorized units X the rate for comparable agency personal assistance services). The Total CD-PASS IBA (TIBA) is the annualized budget amount calculated to cover reimbursement for all CD-PASS services -

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Personal Services Assistance (PSA), Advanced Personal Services Assistance (APSA) and Employer Support Services (ESS). The TIBA is equal to that portion of the annualized cost for Personal Care services and Advanced Supportive/Restorative assistance under the client's existing service plan that CD-PASS services replace;

(C) Authorized Employer Support Service level (based on AA assessment of client's level of need for Employer Supportive Services from review of Consumer Readiness assessment for those new to CD-PASS or performance if existing CD-PASS participant);

(D) Total Annual ESS budget allocation (annualized ESS authorized units X the ESS level rate) and

(E) Client IBA (CIBA) which is equal to the Total CD-PASS IBA minus Total ESS allocation (E=B-D).

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

The TIBA and service unit rates are calculated by the AA during the CD-PASS service eligibility determination process.

Based upon the client record review, client A Self-assessment of Readiness@ to assume employer role and responsibilities and other available information, the AA authorizes a level of support to cover Employer Support Service needs. This process establishes the monthly rate for Employer Support Services. Thereafter, as part of the service planning authorization process at a minimum of annually, the AA, in consultation with the client reviews and updates the authorized level of Employer Support Services.

(G) The PSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Personal Care (PC) services under the client's existing service plan and the result is divided by the total number of PC units authorized per month.

(i) The allocation of portions of PSA rate to cover salary, mandatory taxes, Worker's Compensation insurance

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and optional benefits is determined individually for each client using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;

(ii) If both APSA and PSA units are being authorized the ESS monthly rate amount employed in the PSA rate determination is in proportion to the units of PSA to combined PSA plus APSA units;

(H) The APSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Advanced Supportive/Restorative (ASR) assistance services under the client's existing service plan and the result divided by the total number of ASR units authorized per month.

(i) The allocation of portions of APSA rate to cover salary, mandatory taxes, Worker's Compensation insurance and optional benefits is determined individually for each client using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;

(ii) If both APSA and PSA units are being authorized, the ESS monthly rate amount employed in the APSA rate determination is in proportion to the units of APSA to combined PSA plus APSA units.

(I) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the consumer's need for CD-PASS services. If the client's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional client need. The AA, upon favorable review, authorizes the amended plan and updates the client's IBA. Service amendments based on changes in client need for services do not change an existing PSA or APSA rate. The client, with assistance from the ESSP, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

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(b) The AA approved ADvantage service plan is the basis for the MMIS service prior authorization, specifying:

- (1) service;
- (2) service provider;
- (3) units authorized; and
- (4) begin and end dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to SURS for follow-up investigation.

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ADvantage program clients must be Medicaid eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility. The number of clients who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or NF level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have mental retardation or a cognitive impairment related to the developmental disability.

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

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see OAC 317:35-17-3(d)]; and

(C) meet program eligibility criteria [see OAC 317:35-17-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an

annually capped number of persons who are categorically needy (refer to OKDHS Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable Medicaid cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate Medicaid enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap. To meet program cost effectiveness eligibility criteria, the annualized cost of a client's ADvantage services cannot exceed the ADvantage program services expenditure cap unless approved by the Administrative Agent (AA) under one of the exceptions listed in (1)- (5) of this subsection. The cost of the service plan furnished to a client may exceed the expenditure cap only when all of the increased expenditures above the cap are due solely to:

(1) a one-time purchase of home modifications and/or specialized medical equipment; and/or

(2) documented need for a temporary (not to exceed a 60-day limit) increase in frequency of service or number of services to prevent institutionalization; or

(3) expenditures are for ADvantage Hospice services;

(4) expenditures in excess of the cap are for prescribed drugs, which would be paid by Medicaid if the individual were receiving services in a nursing home; and/or

(5) expenditures are for Institution Transition Services, and the annualized expenditures for ADvantage services to a client under any combination of these circumstances can reasonably be expected to be no more than 200% of the individual cap.

(c) Services provided through the ADvantage waiver are:

(1) case management or Comprehensive Home Care (CHC) case management;

(2) respite or CHC in-home respite;

- (3) adult day health care;
- (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 or CHC advanced supportive/restorative assistance;
- (8) skilled nursing or CHC skilled nursing;
- (9) home delivered meals;
- (10) hospice care;
- (11) medically necessary prescription drugs within the limits of the waiver;
- (12) personal care (state plan), ADvantage personal care, or CHC personal care;
- (13) Personal Emergency Response System (PERS);
- (14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
- (15) Institution Transition Services; and
- (16) Medicaid medical services for individuals age 21 and over within the scope of the State Plan.

(d) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

- (1) an open ADvantage 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 client. If the AA determines all ADvantage waiver slots are filled, the client cannot be certified on the OKDHS computer system as eligible for

ADvantage services and the client's name is placed on a waiting list for entry as an open slot becomes available. ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for persons that have a developmental disability and those that do not have a developmental disability.

(2) the client is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have mental retardation or a cognitive impairment.

(3) the client 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 client or other household visitors.

(e) The AA determines ADvantage program eligibility through the service plan approval process. The following criteria are used to make the ADvantage program eligibility determination that a client is not eligible:

(1) if the client's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver client's health, safety, or welfare can be maintained in their home. If a client's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the client's health, safety or welfare in their home cannot be assured.

(2) if the client 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 client or other household visitors.

(4) if the client's needs are being met, or do not require

ADvantage services to be met, or if the client would not require institutionalization if needs are not met.

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

(f) The case manager provides the AA with professional documentation 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 client is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the AA will provide technical assistance to the Provider for transitioning the client to other services.

(g) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

(h) The AA provides OKDHS with notification that the client is no longer program eligible.

317:35-17-14. Case Management services

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

(1) Within one working day of receipt of an ADvantage referral from the AA, the case management supervisor assigns a case manager to the client. Within three working days of being assigned an ADvantage client, the case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the client, service provider, case manager, Administrative Agent 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 client's UCAT identified primary physician that the client has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the client'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 10 working days of the receipt of ADvantage referral, or the annual re-assessment visit, the case manager completes and submits to the case management supervisor an individualized care plan and service plan for the client. The care plan and service plan are based on the client'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 client. 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 client, a nurse from the ADvantage in-home care provider chosen by the client, and the case manager. Otherwise, the client 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 client signs and indicates review/agreement with the care plan and service plan

by indicating acceptance or non-acceptance of the plans. The client, the client'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 client signs with a mark. If the client refuses to cooperate in development of the service plan, or, if the client 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 clients that require AA intervention.

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

(B) The AA may implement a service plan without the client's signature if the AA has developed an Addendum to the Rights and Responsibilities Agreement for the client. For these clients the presence of a document that "requires" their signature may itself trigger a "conflict". In these circumstances, mental health/behavioral issues may prevent the client 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 client'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 client 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 client 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 clients. The CDA/CM educates the client about their rights and responsibilities as well as about community resources, service choices and options available to the client to meet CD-PASS service goals and objectives.

(B) The client may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing client employer responsibilities. If the client 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 client, the designee and the client'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 client has legal standing to be the client's designated "authorized representative".

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

(C) The CDA/CM provides support to the client 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 client 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-center 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 client and their representative, or support team, are given the requisite information to assume a controlling role in the development, implementation and management of the client'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 client, 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 client define support needs, service goals and service preferences including access to and use of generic community resources. Consistent with client-direction and preferences, the CDA/CM provides information and helps the client locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the client in translating the assessment of client needs and preferences into an individually tailored, personalized service plan.

(E) To the extent the client prefers, the CDA/CM develops assistance to meet client 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 client determines with the PSA to be hired, a start

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

(i) If the client's APSA has been providing Advanced Supportive Restorative Assistance to the client 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 client and APSA attest that the APSA has been performing the specific Health Maintenance tasks to the client'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 client's well being and the quality of supports and services and assists the client in revising the PSA services plan as needed. If the client'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 client need and forwards the plan amendment to the AA for authorization and update of the client'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 clients and ADvantage service providers under the following circumstances:

(i) A claim is formally registered with the CDA/CM by the client (or the client's family or "authorized representative"), the AA, or a provider that the disagreement poses a significant risk to the client'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 client, or about a behavior/action of the provider.

(K) The CDA/CM and the client prepare an emergency back-up/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 client 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 client 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 makes a copy of the plans and other client original documents for the client file, faxes a copy of the plan to the AA and forwards the original care plan and service plan and required documents.

(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 client 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 client, gives the client 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 Administrative Agent certifies the individual service plan and all service plan amendments for each ADvantage client. When the AA verifies client ADvantage eligibility, plan cost effectiveness, that service providers are ADvantage authorized and Medicaid contracted, and that the delivery of ADvantage services are consistent with the client'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 client (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 three 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 client 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 client'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 client'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. The AA approves or denies the care plan and service plan changes within two working days of receipt of the plan.

(2) The client 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 client 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 client'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 client may, as appropriate, be authorized for a new service plan or be eligible for a different service program. If the client is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the client's dated signature indicating voluntary withdrawal for ADvantage program services. If unable to obtain the client'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 client'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.