Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
September 3, 2014
1:30 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

I. Welcome, Roll Call, and Dr. Crawford's Comments, Introduction of new delegates and alternates.

II. Approval of Minutes of the June 11, 2014 Medical Advisory Committee Meeting

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: Gloria Hudson, OHCA Director of General Accounting
   a. June 30, 2014 Financial Summary
   b. June 30, 2014 Financial Detail Report

VI. Budget Summary, SFY 2015: Vickie Kersey, OHCA Purchasing Manager

VII. SoonerCare Operations Update: Becky Pasternik-Ikard, OHCA Deputy State Medicaid Director
   a. Behavioral Health
   b. Population Care Management
   c. Member Services
   d. Provider Services

VIII. Stratetic Planning Conference report: Buffy Heater, OHCA Planning and Development Manager

IX. Action Items: Joseph Fairbanks, OHCA Policy Development Coordinator
   a. Discussion on Proposed Rule Change
   b. Vote on Proposed Rule Changes

X. Six Informational Items (No Discussion): Joseph Fairbanks

XI. New Business

XII. Adjourn

Next Meeting: Wednesday, November 20, 2014, 1:00 PM; 4345 Lincoln, OKC

Oklahoma Health Care Authority

MEDICAL ADVISORY COMMITTEE MEETING

MINUTES

JUNE 11, 2014

I. Dr. Crawford called the meeting of the Oklahoma Health Care Authority's (OHCA) Medical Advisory Committee (MAC) to order at 1:03 PM. He introduced new delegates, Dr. Kirkpatrick and Dr. Hamil and alternates, Ms. Collins and Dr. Poyner. He called for a roll call and a quorum was established.

Delegates present: Ms. Brinkley, Ms. Case, Dr. Crawford, Ms. Felty, Dr. Gastorf, Dr. Grogg, Dr. Hamil, Ms. Hastings, Mr. Jones, Dr. Kirkpatrick, Dr. Post, Ms. Pratt-Reid, Dr. Rhynes, Ms. Slatton-Hodges, Mr. Snyder, Mr. Tallent, Dr. Woodward; by phone: Ms. Booten-Hiser, Ms. Mays, Dr. Wright. (20)

Alternates present: Ms. Baker, Dr. Rhoades, Ms. Pryor, Mr. Raybern, Ms. Collins (5)

Delegates absent: Mr. Goforth, Ms. Moran, Mr. Patterson, Dr. Simon (4)

II. Dr. Crawford noted that there were a large number of public comments representative of the capacity crowd in the Charles Ed McFall Boardroom. (169 signed in as visitors) He asked that each speaker limit their remarks to two minutes.

The speakers in order were: Valene Whiteneck, Steven Foster, Nancy Welch, Toby Pedford, Anthony Freitas, Roe Nordoni, Randy Tate, Sammie Drinkard, Erica Ward, Debbie Spaeth, Laura Boyd, Theron Forshee, Darnesha Sellers, Vurtina Long, Garland Pruitt, Melissa Holt, Robert Lobato, Jeanetta Wrice, Andrew Merritt, Tayrin Saldivar, Todd Palmer, Verna Foust, Taylor Randolph, Melissa Williams, Richard Walton, , Dewell Brewer, Richard DeSirey, , Terri Clark, Clint Patent, Summer King, and Sheryl Hunter-Wilson. (32) A couple of the speakers supported the recommendation for Proposed Rule Change (PRC) 14-10. The others opposed PRC 14-10 citing the loss of services to individuals who had greatly benefited from the services in the past, the loss of jobs for the Behavioral Health Rehabilitation Specialists (BHRS) who provide those services in a field where there is already a shortage of providers, and the need to slow-down to assess the impact of the PRC on SoonerCare members and perhaps share the economic impact with other program services.

III. Dr. Crawford remarked that the MAC was an advisory committee only - with the Board of OHCA above it to accept or reject the committee's recommendations. He went on to say that the budget restraints that had prompted the rule change came down from the Legislature. He then asked for a motion to approve of the minutes from the May 15, 2014 meeting of the MAC. Mr. Tallent moved for approval and Dr. Gastorf seconded the motion. The recording secretary noted a

DRAFT

correction in the minutes on page 4, Section IX, f. Mr. Tallent amended his motion to include the correction. The ensuing vote was unanimous to approve.

IV. Four members of the MAC made comments.

Dr. Hamil read a letter from the Oklahoma Psychology Association (Addendum A)

Mr. Tallent remarked that the financial reduction originated as a reduction of the federal matching money, not as a state cut.

Ms. Pryor noted that PRC 14-10 does not eliminate a category of service nor does it preclude services by case managers

Ms. Slatton-Hodges suggested that Traylor Rains would clear up some misunderstandings in his presentation to follow. She noted that the change had been reviewed by the Behavioral Health Advisory Committee (BHAC) on Monday where other options were discussed by a variety of behavioral health providers after which a phrase was added allowing children with “504” educational plans that included “emotional disturbance “ to retain eligibility. She noted that Oklahoma ranks 48th among the states regarding expenditures for mental health issues. The delay in receiving new budget figures mandated a faster pace to identify changes because each month of delay in implementing changes meant more cuts needed to balance the budget. Her staff passed out copies of the text of the rule with the most recent changes. (Addendum B)

V. Traylor Rains, the Oklahoma Department of Mental Health and Substance Abuse Services’ (DMH) Director, Policy and Planning detailed the other options considered besides PRC 14-10, Psychosocial rehabilitation (PSR) Service Eligibility Criteria, and then read the summary of the proposed change.

Mr. Rains described two other options that were considered before and during the BHAC’s meeting. The options included reducing billable hours per member per week from the current limit of 40 hours and reducing the length of prior authorization for intensive out-patient treatment from the current default of 90 days.

In discussing PRC 14-10, Mr. Rains noted that PSR services were maintained for the most needy, and were reopened for students with 504 Plans and students with a referral from a school psychologist. Centers for Medicaid and Medicare Services (CMS) reviewed the changes, Mr. Rains said, and determined that they were not arbitrary. He also discussed the definition of rehabilitation as defined in the contract between CMS and OHCA called the State Plan Amendment; terms such as preventive and skill-building were not included in the definition.

Mr. Raybern asked for clarification about the impact on children in state custody. Mr. Rains said that the criteria for eligibility did not include custody children as a group.

Children in custody must also meet the new service eligibility criteria. Ms. Slatton-Hodges pointed out that children in Therapeutic Foster Care (TFC) were not impacted because those services were authorized in a different rule. Mr. Raybern went on to express concerns that removing preventive services would make level one and two cases escalate to level three and four faster, only postponing the costs. He asked about the availability of providers of the higher level services and was told that the current number was adequate though a cut in provider rates of as little as 2% would jeopardize beds. Mr. Rains also noted that DMH had met with that group of providers who agreed that preserving PSR for only the neediest was preferable to rate cuts. Mr. Raybern finished with an observation that most of the savings would be realized by limiting services to children.

Ms. Case asked if the change would impact substance abuse services (SAS). Mr. Rains said that SAS meet the federal definition of rehabilitation and would continue to be reimbursable. She asked about TFC and was told that TFC services go through a different authorization process. Ms. Slatton–Hodges noted that PRC 14-10 only addressed out-patient services.

Dr. Hamil questioned the term, “for mental health reasons” under a Social Security Administration (SSA) disability determination since SSA’s determination does not spell out reasons. Mr. Rains responded that a review of claims would verify the reasons. Ms. Felty reiterated Dr. Hamil’s claim and pointed out that individual education plans (IEP) contain multiple reasons but often the primary reason is not for emotional disturbance. Dr. Hamil brought up OHCA’s Provider Manual’s statement concerning the exclusion of payments to third parties if an IEP invokes services. Mr. Rains noted that OHCA and DMH would give precedence to the rule over the Provider Manual and would later revise the manual to be consistent with the new rules. Dr. Hamil persisted with a concern that psychologists not employed by the school would be bound to serve the school instead of the patient and the sharing of personal health information (PHI) needed for evaluation is legally restricted. Ms. Slatton-Hodges noted that the member could grant access. She also addressed Ms. Felty’s concern and suggested that the language could be modified to restrict reasons for disability only to the primary reason. Ms. Felty concurred.

Mr. Hamil questioned whether or not the rules for making changes in rules were followed in regards to the impact statement that accompanied the announcement on the website of PRC 14-10. He noted that the impact statement identified small businesses (providers) but did not identify any impact on children as a class of people.

Dr. Crawford asked about the consequences of delaying the vote on recommending PRC 14-10. Nicole Nantois, Chief of Legal Services for OHCA said that the OHCA Board could act without MAC’s vote. Mr. Rains responded with an estimate that a delay in implementing the rule change would mean only a six months savings to a budget that

DRAFT

needed eleven months savings. Dr. Crawford asked about the emergency nature of the PRC and Mr. Rains reiterated the limited time to react to a last minute budget but a full year's worth of savings to find.

Mr. Tallent moved for a vote of recommendation for PRC 14-10; Ms. Slatton-Hodges made the second. During the discussion before the vote, Ms. Brinkley addressed the public visitors suggesting they use the emotion expressed during the public comments to contact their representatives because cuts next year will be worse and little could be done to change the course of PRC 14-10. Ms. Case added that when contacting legislators, callers should ask why they did not expand Medicaid to forego this sort of situation.

Dr. Crawford asked for a roll call vote. Yes votes: Ms. Baker, Ms. Booten-Hiser, Ms. Case, Dr. Rhoades, Dr. Crawford, Ms. Felty, Ms. Pryor, Dr. Gastorf, Dr. Grogg, Ms. Tandie, Dr. Kirkpatrick, Ms. Collins, Dr. Post, Dr. Rhynes, Ms. Slatton-Hodges, Mr. Snyder, Mr. Tallent, and Dr. Wright. (18) No votes: Ms. Brinkley, Dr. Hamil, Mr. Jones, Ms. Mays, Ms. Pratt-Reid, Mr. Raybern, and Dr. Woodward. (7) PRC 14-10 was recommended by a majority. Dr. Crawford declared a ten-minute recess.

VI. Carter Kimble, OHCA Director of Governmental Relations reported that the 54th Legislature did not pass a rule resolution, leaving the responsibility of approving all of the Administrative Rule changes to the governor who had until June 30 to make a final decision. He noted that the date for implementing the proposed rule changes, normally July 1 or a date specified, would vary due to the differential between the date of signature and the date of publishing in the Official Register.

One bill that will probably come back, HB2906, is prompting OHCA to convene stake-holder meetings to prepare contingencies if the bill, calling for a study of the over-utilization of emergency room services by SoonerCare members goes through. He invited MAC delegates to participate.

VII. Carrie Evans, Chief Financial Officer gave the Financial Report for the 10 months ending April 30, 2014 in lieu of Gloria Hudson. Ms. Evans reported that the current variance was expected to continue to grow to meet the projection of $40M at fiscal year's end. She confirmed Dr. Hamil's question about the $40M variance inclusion in the budgetary projections. Ms. Evans could not compare the behavioral health claims figures from OHCA's financial reports with DMH's budget to answer further questions from Dr. Hamil.

VIII. Becky Pasternik-Ikard, Deputy State Medicaid Director, reported stable rates of growth for SoonerCare member and provider enrollment. Ms. Case asked about the 23,000 "Net Enrollee Count Change from Previous Month Total." Ms.

Pasternik-Ikard explained that during the period January – March 2014, OHCA was required by CMS not to disenroll or "hold harmless" members who potentially would no longer qualify under the new MAGI standards. Subsequently, OHCA mailed 77,000 disenrollment notices. The lack of a response from some members to renew eligibility could be attributed in part to moving out of state, no longer meeting income guidelines or not acting within the timeframe.

IX. Joseph Fairbanks, Policy Development Coordinator, reviewed the process by which proposed rule changes become permanent rules and noted that the delay in legislative/gubernatorial approval would delay their promulgation in the Official Register until July 17, 2014 making that the earliest date the PRCs voted upon by the MAC could become effective. Emergency Rules like PRC 14-10 may not be submitted until the regular rule changes are published, so August 1, 2014 is the soonest they can become law. Mr. Fairbanks went on to read the Proposed Waiver and State Plan Amendment Summaries included in the MAC Agenda: "Dental," "Moving to an SSI Criteria State for Determining Medicaid Eligibility for Aged, Blind, and Disabled Individuals," "Hospital Presumptive Eligibility," and "Home and Community-Based Waiver Services."

Mr. Rains read three of the summaries that applied to behavioral health rules including two he had mentioned earlier, "Limit on Outpatient Behavioral Health Provider Billable Hours," and "Prior Authorizations for Partial Hospitalization." He also covered "Coordinated Care Health Homes" and said that it was DMH's intention to send out requests for proposals soon for a January 1, 2015 implementation date.

X. After Dr. Crawford announced that the next meeting was scheduled for Wednesday, September 17, 2014, Dr. Rhynes moved for adjournment; Mr. Raybern seconded; and the meeting adjourned by acclamation at 3:45.

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FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2014
Submitted to the CEO & Board

- Revenues for OHCA through June, accounting for receivables, were **$3,926,985,946** or **.1% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,881,557,806 or 1.4% under** budget.
- The state dollar budget variance through June is a **positive $56,379,759.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	22.2
Administration	8.6
Revenues:	
Unanticipated Revenue	15.7
Drug Rebate	16.3
Taxes and Fees	(8.8)
Overpayments/Settlements	2.4
Total FY 14 Variance	**$ 56.4**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 205: Supplemental Hospital Offset Payment Program Fund 4
Fund 230: Quality of Care Fund Summary 5
Fund 245: Health Employee and Economy Act Revolving Fund 6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer
Treatment Revolving Fund 7

Oklahoma Health Care Authority

Summary of Revenues & Expenditures: OHCA
For the Fiscal Year Ended June 30, 2014

REVENUES	FY14 Budget YTD	FY14 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 950,701,728	$ 946,812,805	$ (3,888,923)	(0.4)%
Federal Funds	2,101,419,909	2,048,780,753	(52,639,156)	(2.5)%
Tobacco Tax Collections	55,654,103	50,731,193	(4,922,910)	(8.8)%
Quality of Care Collections	80,794,836	77,468,232	(3,326,604)	(4.1)%
Prior Year Carryover	41,811,007	41,811,007	-	0.0%
Unanticipated Revenue	-	15,683,810	15,683,810	100.0%
Federal Deferral - Interest	230,896	230,896	-	0.0%
Drug Rebates	188,508,819	233,914,648	45,405,829	24.1%
Medical Refunds	48,559,263	55,103,747	6,544,484	13.5%
SHOPP	439,528,791	439,528,791	-	0.0%
Other Revenues	16,656,798	16,920,064	263,265	1.6%
TOTAL REVENUES	**$ 3,923,866,151**	**$ 3,926,985,946**	**$ 3,119,795**	**0.1%**

EXPENDITURES	FY14 Budget YTD	FY14 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 60,434,407**	**$ 50,228,077**	**$ 10,206,330**	**16.9%**
ADMINISTRATION - CONTRACTS	**$ 125,276,455**	**$ 112,554,530**	**$ 12,721,925**	**10.2%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	37,094,628	36,385,970	708,657	1.9%
Acute Fee for Service Payments:				
Hospital Services	939,755,305	923,318,031	16,437,274	1.7%
Behavioral Health	22,530,724	20,581,377	1,949,347	8.7%
Physicians	513,293,311	505,404,273	7,889,038	1.5%
Dentists	149,572,592	143,386,311	6,186,281	4.1%
Other Practitioners	46,131,081	42,073,053	4,058,028	8.8%
Home Health Care	22,091,488	20,617,102	1,474,385	6.7%
Lab & Radiology	67,332,180	65,959,003	1,373,178	2.0%
Medical Supplies	51,277,019	46,239,717	5,037,302	9.8%
Ambulatory/Clinics	116,777,615	112,254,689	4,522,926	3.9%
Prescription Drugs	425,732,775	451,794,797	(26,062,022)	(6.1)%
OHCA TFC	1,729,232	2,009,305	(280,073)	0.0%
Other Payments:				
Nursing Facilities	580,765,542	572,855,252	7,910,290	1.4%
ICF-MR Private	59,778,856	58,724,681	1,054,175	1.8%
Medicare Buy-In	136,396,322	136,211,348	184,974	0.1%
Transportation	62,574,308	64,900,851	(2,326,543)	(3.7)%
MFP-OHCA	1,623,149	952,877	670,273	0.0%
EHR-Incentive Payments	31,836,261	31,836,261	-	0.0%
Part D Phase-In Contribution	76,064,816	76,609,978	(545,162)	(0.7)%
SHOPP payments	406,660,322	406,660,322	-	0.0%
Total OHCA Medical Programs	**3,749,017,527**	**3,718,775,200**	**30,242,327**	**0.8%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,934,817,771**	**$ 3,881,557,806**	**$ 53,259,964**	**1.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (10,951,620)**	**$ 45,428,139**	**$ 56,379,759**	

Oklahoma Health Care Authority

Total Medicaid Program Expenditures

by Source of State Funds

For the Fiscal Year Ended June 30, 2014

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 36,682,643	$ 36,369,100	$ -	$ 296,673	$ -	$ 16,870	$ -
Inpatient Acute Care	805,935,343	589,839,223	486,687	7,791,148	50,741,699	2,022,358	155,054,229
Outpatient Acute Care	288,740,304	275,914,885	41,604	8,512,239	-	4,271,575	-
Behavioral Health - Inpatient	25,910,229	12,111,725	-	481,302	-		13,317,202
Behavioral Health - Psychiatrist	8,469,652	8,469,652	-	-	-	-	-
Behavioral Health - Outpatient	25,710,871	-	-	-	-	-	25,710,871
Behavioral Health Facility- Rehab	293,768,712	-	-	-	-	83,295	293,685,418
Behavioral Health - Case Management	10,421,228	-	-	-	-	-	10,421,228
Behavioral Health - PRTF	93,137,105	-	-	-	-	-	93,137,105
Residential Behavioral Management	20,833,638	-	-	-	-	-	20,833,638
Targeted Case Management	66,248,017	-	-	-	-	-	66,248,017
Therapeutic Foster Care	2,009,305	2,009,305	-	-	-	-	-
Physicians	562,184,234	431,165,754	58,101	11,127,931	67,901,698	6,278,721	45,652,029
Dentists	143,450,130	136,555,287	-	63,819	6,798,911	32,113	-
Mid Level Practitioners	3,520,833	3,461,365	-	55,670	-	3,799	-
Other Practitioners	38,828,013	37,116,404	446,364	220,123	1,035,806	9,316	-
Home Health Care	20,619,063	20,589,183	-	1,961	-	27,919	-
Lab & Radiology	68,899,981	65,274,385	-	2,940,979	-	684,618	-
Medical Supplies	46,759,384	43,477,484	2,711,537	519,667	-	50,696	-
Clinic Services	114,644,099	102,130,011	-	1,085,258	-	241,241	11,187,589
Ambulatory Surgery Centers	10,260,460	9,865,921	-	377,023	-	17,516	-
Personal Care Services	13,291,966	-	-	-	-	-	13,291,966
Nursing Facilities	572,855,252	320,746,680	211,652,291	-	40,447,958	8,323	-
Transportation	64,686,155	58,791,951	2,631,894	-	3,205,680	56,630	-
GME/IME/DME	138,471,093	-	-	-	-	-	138,471,093
ICF/MR Private	58,724,681	47,029,857	10,839,703	-	855,121	-	-
ICF/MR Public	36,846,889	-	-	-	-	-	36,846,889
CMS Payments	212,821,326	212,120,417	700,909	-	-	-	
Prescription Drugs	467,909,057	402,810,300	-	16,114,259	47,237,047	1,747,451	-
Miscellaneous Medical Payments	214,775	207,190	-	79	-	7,506	-
Home and Community Based Waiver	172,790,433	-	-	-	-	-	172,790,433
Homeward Bound Waiver	90,178,069	-	-	-	-	-	90,178,069
Money Follows the Person	11,090,798	952,877	-	-	-	-	10,137,921
In-Home Support Waiver	23,896,415	-	-	-	-	-	23,896,415
ADvantage Waiver	183,308,381	-	-	-	-	-	183,308,381
Family Planning/Family Planning Waiver	11,023,179	-	-	-	-	-	11,023,179
Premium Assistance*	45,821,868	-	-	45,821,868		-	-
EHR Incentive Payments	31,836,261	31,836,261	-	-	-	-	-
SHOPP Payments**	406,660,323	406,660,323	-	-	-	-	-
Total Medicaid Expenditures	**$ 5,229,460,165**	**$3,255,505,540**	**$ 229,569,090**	**$ 95,409,999**	**$ 218,223,919**	**$ 15,559,946**	**$1,415,191,671**

* Includes $45,434,243.20 paid out of Fund 245 and **$182,116,227 paid out of Fund 205

Summary of Revenues & Expenditures: Other State Agencies
For the Fiscal Year Ended June 30, 2014

REVENUE	FY14 Actual YTD
Revenues from Other State Agencies	$ 574,025,669
Federal Funds	910,731,752
TOTAL REVENUES	**$ 1,484,757,421**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	$ 172,790,433
Money Follows the Person	10,137,921
Homeward Bound Waiver	90,178,069
In-Home Support Waivers	23,896,415
ADvantage Waiver	183,308,381
ICF/MR Public	36,846,889
Personal Care	13,291,966
Residential Behavioral Management	15,270,351
Targeted Case Management	48,857,703
Total Department of Human Services	**594,578,127**
State Employees Physician Payment	
Physician Payments	45,652,029
Total State Employees Physician Payment	**45,652,029**
Education Payments	
Graduate Medical Education	86,118,268
Graduate Medical Education - PMTC	5,022,187
Indirect Medical Education	31,088,706
Direct Medical Education	16,241,932
Total Education Payments	**138,471,093**
Office of Juvenile Affairs	
Targeted Case Management	2,995,650
Residential Behavioral Management	5,563,287
Total Office of Juvenile Affairs	**8,558,937**
Department of Mental Health	
Case Management	10,421,228
Inpatient Psych FS	13,317,202
Outpatient	25,710,871
PRTF	93,137,105
Rehab	293,685,418
Total Department of Mental Health	**436,271,824**
State Department of Health	
Children's First	1,957,941
Sooner Start	2,160,532
Early Intervention	5,607,681
EPSDT Clinic	1,968,973
Family Planning	(155,652)
Family Planning Waiver	11,134,355
Maternity Clinic	55,934
Total Department of Health	**22,729,764**
County Health Departments	
EPSDT Clinic	783,214
Family Planning Waiver	44,475
Total County Health Departments	**827,689**
State Department of Education	**127,359**
Public Schools	**6,701,684**
Medicare DRG Limit	**144,952,312**
Native American Tribal Agreements	**6,218,935**
Department of Corrections	**2,615,116**
JD McCarty	**7,486,800**
Total OSA Medicaid Programs	**$ 1,415,191,671**
OSA Non-Medicaid Programs	**$ 76,842,493**
Accounts Receivable from OSA	**$ 7,276,743**

Oklahoma Health Care Authority

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2014, For the Ten Months Ended April 30, 2014

	FY14
REVENUE	**Actual YTD**
Revenues from Other State Agencies	$ 467,424,216
Federal Funds	719,881,733
TOTAL REVENUES	**$ 1,187,305,949**
EXPENDITURES	**Actual YTD**
Department of Human Services	
Home and Community Based Waiver	$ 144,925,264
Money Follows the Person	7,751,284
Homeward Bound Waiver	75,955,577
In-Home Support Waivers	20,134,595
ADvantage Waiver	154,883,044
ICF/MR Public	32,530,538
Personal Care	11,236,310
Residential Behavioral Management	12,691,272
Targeted Case Management	40,438,583
Total Department of Human Services	**500,546,467**
State Employees Physician Payment	
Physician Payments	37,969,792
Total State Employees Physician Payment	**37,969,792**
Education Payments	
Graduate Medical Education	44,367,799
Graduate Medical Education - PMTC	3,412,990
Indirect Medical Education	31,088,706
Direct Medical Education	12,181,449
Total Education Payments	**91,050,944**
Office of Juvenile Affairs	
Targeted Case Management	2,500,376
Residential Behavioral Management	4,626,342
Total Office of Juvenile Affairs	**7,126,718**
Department of Mental Health	
Case Management	8,553,895
Inpatient Psych FS	10,712,642
Outpatient	21,761,700
PRTF	79,013,183
Rehab	242,939,399
Total Department of Mental Health	**362,980,819**
State Department of Health	
Children's First	1,826,318
Sooner Start	1,956,772
Early Intervention	5,167,802
EPSDT Clinic	1,798,935
Family Planning	(150,382)
Family Planning Waiver	9,934,789
Maternity Clinic	54,591
Total Department of Health	**20,588,826**
County Health Departments	
EPSDT Clinic	673,545
Family Planning Waiver	32,277
Total County Health Departments	**705,822**
State Department of Education	**99,970**
Public Schools	**5,022,475**
Medicare DRG Limit	**77,702,312**
Native American Tribal Agreements	**5,680,146**
Department of Corrections	**2,028,503**
JD McCarty	**6,740,543**
Total OSA Medicaid Programs	**$ 1,118,243,336**
OSA Non-Medicaid Programs	**$ 64,660,766**
Accounts Receivable from OSA	**$ (4,401,847)**

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY 14 Revenue
SHOPP Assessment Fee	$ 178,616,889
Federal Draws	260,325,604
Interest	148,131
Penalties	20,881
State Appropriations	(22,700,000)
TOTAL REVENUES	$ 416,411,504

EXPENDITURES	Quarter	Quarter	*Thru Fund 340* Quarter	Quarter	FY 14 Expenditures
Program Costs:	7/1/13 - 9/30/13	10/1/13 - 12/31/13	1/1/14 - 3/31/14	4/1/14 - 6/30/14	
Hospital - Inpatient Care	76,710,371	86,962,208	87,919,865	93,110,378	$ 344,702,822
Hospital -Outpatient Care	2,748,407	2,899,948	14,433,147	15,081,373	$ 35,162,875
Psychiatric Facilities-Inpatient	5,785,055	6,483,431	6,540,191	6,928,169	$ 25,736,846
Rehabilitation Facilities-Inpatient	248,410	278,398	257,838	273,133	$ 1,057,779
Total OHCA Program Costs	85,492,242	96,623,985	109,151,041	115,393,054	$ 406,660,322
Total Expenditures					$ 406,660,322

CASH BALANCE	$ 9,751,182

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
For the Fiscal Year Ended June 30,2014

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 77,428,681	$ 77,428,681
Interest Earned	39,552	39,552
TOTAL REVENUES	**$ 77,468,232**	**$ 77,468,232**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 208,002,557	$ 74,880,920	
Eyeglasses and Dentures	280,055	100,820	
Personal Allowance Increase	3,369,680	1,213,085	
Coverage for DME and supplies	2,711,535	976,153	
Coverage of QMB's	1,032,756	371,792	
Part D Phase-In	700,909	700,909	
ICF/MR Rate Adjustment	5,471,581	1,969,769	
Acute/MR Adjustments	5,368,122	1,932,524	
NET - Soonerride	2,631,894	947,482	
Total Program Costs	**$ 229,569,088**	**$ 83,093,453**	**$ 83,093,453**
Administration			
OHCA Administration Costs	$ 470,623	$ 235,311	
PHBV - QOC Exp	-	-	
OSDH-NF Inspectors	800,000	800,000	
Mike Fine, CPA	16,000	8,000	
Total Administration Costs	**$ 1,286,623**	**$ 1,043,311**	**$ 1,043,311**
Total Quality of Care Fee Costs	**$ 230,855,710**	**$ 84,136,764**	
TOTAL STATE SHARE OF COSTS			**$ 84,136,764**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

Oklahoma Health Care Authority

Fund 245: Health Employee and Economy Improvement Act Revolving Fund
For the Fiscal Year Ended June 30, 2014

REVENUES	FY 13 Carryover	FY 14 Revenue	Total Revenue
Prior Year Balance	$ 10,427,850	$ -	$ 3,697,555
State Appropriations	-	-	(3,000,000)
Tobacco Tax Collections	-	41,725,339	41,725,339
Interest Income	-	217,816	217,816
Federal Draws	375,153	30,459,539	30,459,539
All Kids Act	(6,745,162)	238,167.65	238,168
TOTAL REVENUES	**$ 4,057,841**	**$ 72,640,862**	**$ 73,100,250**

EXPENDITURES		FY 13 Expenditures	FY 14 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 44,902,854	$ 44,902,854
	College Students		338,450	338,450
	All Kids Act		580,564	580,564
Individual Plan				
	SoonerCare Choice		$ 285,144	$ 102,652
	Inpatient Hospital		7,759,083	2,793,270
	Outpatient Hospital		8,377,377	3,015,856
	BH - Inpatient Services-DRG		464,686	167,287
	BH -Psychiatrist		-	-
	Physicians		11,031,137	3,971,209
	Dentists		45,925	16,533
	Mid Level Practitioner		54,910	19,768
	Other Practitioners		212,493	76,498
	Home Health		1,961	706
	Lab and Radiology		2,909,913	1,047,569
	Medical Supplies		514,237	185,125
	Clinic Services		1,066,487	383,935
	Ambulatory Surgery Center		376,165	135,419
	Prescription Drugs		15,940,184	5,738,466
	Miscellaneous Medical		79	79
	Premiums Collected		-	(1,152,753)
Total Individual Plan			**$ 49,039,782**	**$ 16,501,619**
	College Students-Service Costs		**$ 467,336**	**$ 168,241**
	All Kids Act- Service Costs		**$ 81,013**	**$ 29,165**
Total OHCA Program Costs			**$ 95,409,999**	**$ 62,520,893**
Administrative Costs				
	Salaries	$ 7,360	$ 1,108,437	$ 1,115,797
	Operating Costs	85,634	834,662	920,297

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:

Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund

Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY 14 Revenue	State Share
Tobacco Tax Collections	$ 691,231	$ 691,231
TOTAL REVENUES	**$ 691,231**	**$ 691,231**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 14,119	$ 3,558	
Inpatient Hospital	1,674,086	421,870	
Outpatient Hospital	3,647,302	919,120	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	8,323	2,097	
Physicians	5,305,176	1,336,904	
Dentists	23,574	5,941	
Mid-level Practitioner	3,425	863	
Other Practitioners	8,509	2,144	
Home Health	23,500	5,922	
Lab & Radiology	556,047	140,124	
Medical Supplies	37,690	9,498	
Clinic Services	202,974	51,149	
Ambulatory Surgery Center	14,904	3,756	
Prescription Drugs	1,389,651	350,192	
Transportation	47,261	11,910	
Miscellaneous Medical	7,506	1,892	
Total OHCA Program Costs	$ 12,964,048	$ 3,266,940	
OSA DMHSAS Rehab	$ 71,465	$ 18,009	
Total Medicaid Program Costs	$ 13,035,513	$ 3,284,949	
TOTAL STATE SHARE OF COSTS			**$ 3,284,949**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

FY-15 BUDGET WORK PROGRAM Summary by Program Expenditure

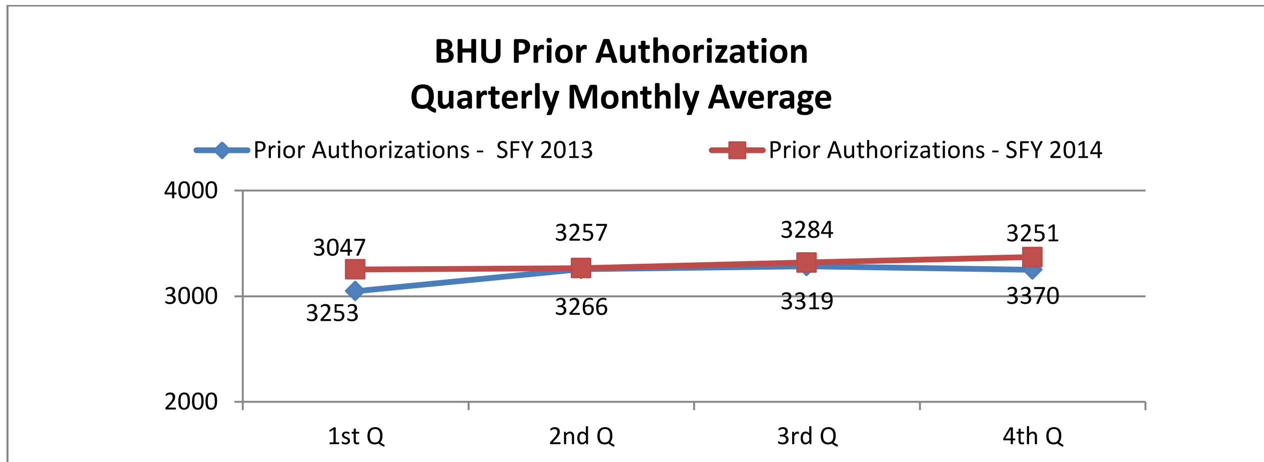
Medical Program	SFY 2014	SFY 2015	Difference	% change
Managed Care - Choice / HAN / PACE	37,094,628	40,290,236	3,195,608	8.6%
Hospitals	939,755,305	899,543,101	(40,212,204)	-4.3%
Behavioral Health	24,259,956	21,903,406	(2,356,550)	-9.7%
Nursing Homes	580,765,542	579,606,680	(1,158,861)	-0.2%
Physicians	513,293,311	501,771,908	(11,521,403)	-2.2%
Dentists	149,572,592	136,303,094	(13,269,498)	-8.9%
Mid-Level Practitioner	4,045,986	3,418,029	(627,957)	-15.5%
Other Practitioners	42,085,096	36,929,783	(5,155,313)	-12.2%
Home Health	22,091,488	21,020,640	(1,070,848)	-4.8%
Lab & Radiology	67,332,180	66,039,801	(1,292,379)	-1.9%
Medical Supplies	51,277,019	40,846,187	(10,430,832)	-20.3%
Clinic Services	106,361,133	107,500,225	1,139,092	1.1%
Ambulatory Surgery Center	10,416,482	9,148,841	(1,267,641)	-12.2%
Prescription Drugs	425,732,775	499,606,461	73,873,686	17.4%
Miscellaneous	317,855	233,454	(84,401)	-26.6%
ICF-MR Private	59,778,856	60,635,132	856,276	1.4%
Transportation	62,256,454	67,249,355	4,992,901	8.0%
Medicare Buy-in	136,396,322	138,694,125	2,297,803	1.7%
Medicare clawback payment	76,064,816	78,014,633	1,949,817	2.6%
SHOPP - Supplemental Hosp Offset Pymt.	363,024,545	454,602,431	91,577,886	25.2%
Money Follows the Person - Enhanced	1,623,149	1,022,695	(600,454)	-37.0%
Electronic Health Records Incentive Pymts	39,788,361	39,788,361	0	0.0%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	3,713,423,232	3,804,257,959	90,834,727	2.4%
Insure Oklahoma - Premium Assistance				
Employer Sponsored Insurance - ESI	51,954,038	49,330,255	(2,623,783)	-5.1%
Individual Plan - IP	63,857,987	48,031,940	(15,826,047)	-24.8%
TOTAL INSURE OKLAHOMA PROGRAM	115,812,025	97,362,195	(18,449,830)	-15.9%
OHCA Administration				
Operations	54,432,496	51,117,766	(3,314,730)	-6.1%
Contracts	54,136,699	47,860,000	(6,276,699)	-11.6%
Insure Oklahoma Admin	4,068,589	3,661,218	(407,371)	-10.0%
Information Services	86,570,945	86,137,036	(433,908)	-0.5%
Grant Mgmt	2,986,598	3,092,030	105,432	3.5%
TOTAL OHCA ADMIN	202,195,327	191,868,051	(10,327,276)	-5.1%
TOTAL OHCA PROGRAMS	**4,031,430,584**	**4,093,488,205**	**62,057,621**	**1.5%**
Other State Agency (OSA) Programs				
Department of Human Services (OKDHS)	614,759,006	609,583,188	(5,175,818)	-0.8%
Oklahoma State Dept of Health (OSDH)	25,535,786	24,352,464	(1,183,322)	-4.6%
The Office of Juvenile Affairs (OJA)	7,678,500	8,782,414	1,103,914	14.4%
University Hospitals (Medical Education Pymnts)	294,574,856	302,727,735	8,152,879	2.8%
Physician Manpower Training Commission	5,604,093	5,363,127	(240,966)	-4.3%
Department of Mental Health (DMHSAS)	406,883,941	375,923,824	(30,960,117)	-7.6%
Department of Education (DOE)	6,971,096	6,500,584	(470,512)	-6.7%
OSU Supplemental / DRG	9,000,000	9,000,000	-	0.0%
Non-Indian Payments	9,348,459	7,573,527	(1,774,932)	-19.0%
Department of Corrections (DOC)	1,144,923	2,704,671	1,559,748	136.2%
JD McCarty	7,124,594	7,475,687	351,093	0.0%
OSA Non-Title XIX	101,659,710	101,659,710	-	0.0%
TOTAL OSA PROGRAMS	**1,490,284,964**	**1,461,646,930**	**(28,638,034)**	**-1.9%**
TOTAL MEDICAID PROGRAM	**5,521,715,547**	**5,555,135,136**	**33,419,587**	**0.6%**

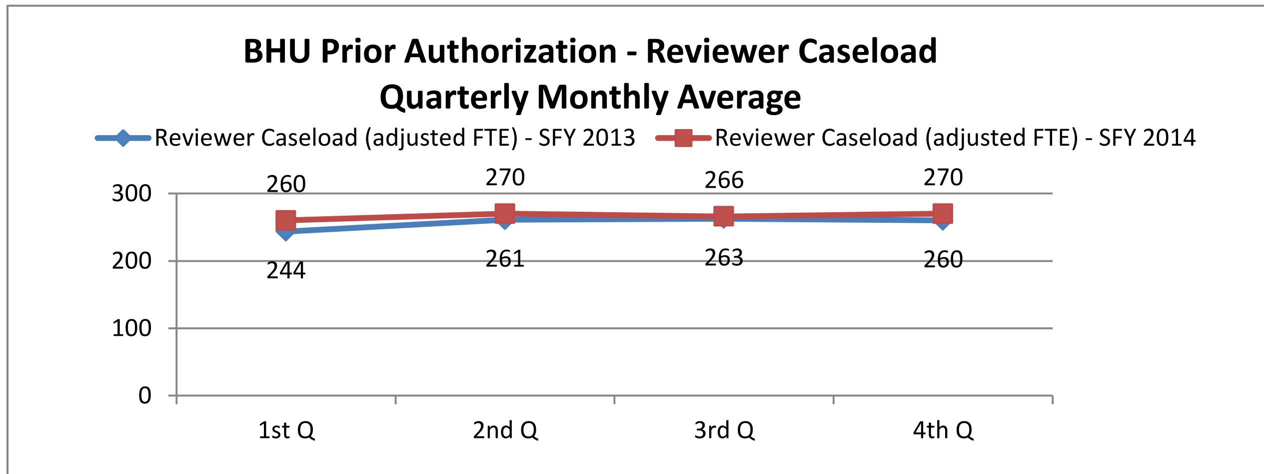
Oklahoma Health Care Authority

FY-15 BUDGET Summary by Revenue Sources

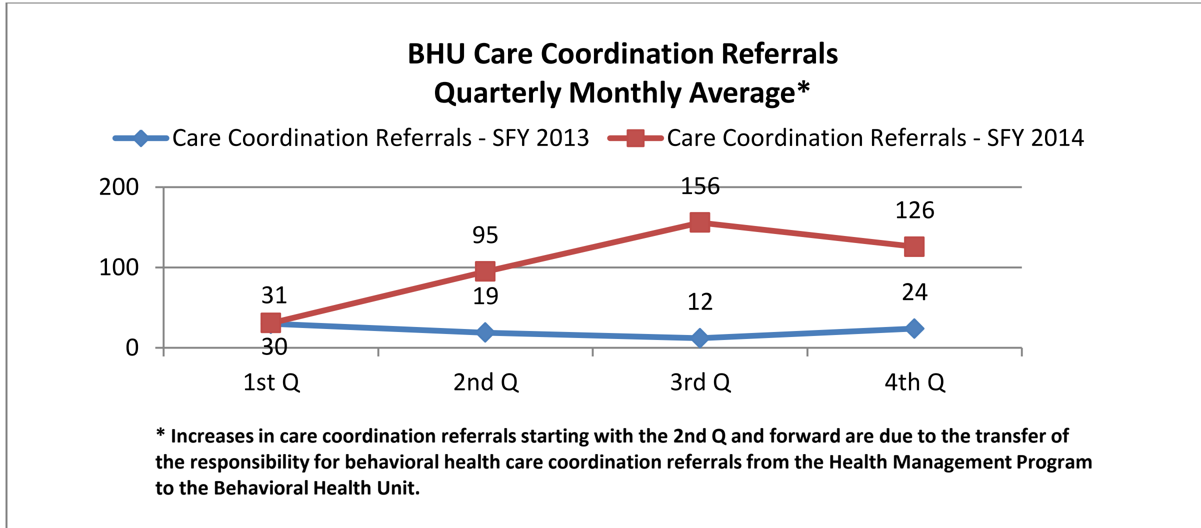
REVENUES	SFY 2014	SFY 2015	Difference	% change
Federal - program	3,206,006,360	3,152,564,968	(53,441,392)	-1.7%
Federal - admin	133,137,996	126,334,415	(6,803,581)	-5.1%
Drug Rebates	176,208,819	230,190,583	53,981,764	30.6%
Medical Refunds	48,559,263	45,226,096	(3,333,167)	-6.9%
NF Quality of Care Fee	81,359,250	77,471,006	(3,888,244)	-4.8%
OSA Refunds & Reimbursements	616,045,989	621,219,029	5,173,040	0.8%
Tobacco Tax	97,227,315	82,160,489	(15,066,826)	-15.5%
Insurance Premiums	7,144,639	3,373,357	(3,771,282)	-52.8%
Misc Revenue	84,000	132,668	48,668	57.9%
Prior Year Carryover	38,811,007	60,006,318	21,195,310	54.6%
Other Grants	2,595,314	281,992	(2,313,322)	-89.1%
Hospital Provider Fee (SHOPP bill)	160,834,320	202,100,356	41,266,036	25.7%
Insure Oklahoma Fund 245 - Transfer	3,000,000	-	(3,000,000)	-100.0%
State Appropriated	950,701,274	954,073,857	3,372,583	0.4%
TOTAL REVENUES	**5,521,715,547**	**5,555,135,136**	**33,419,587**	**0.6%**

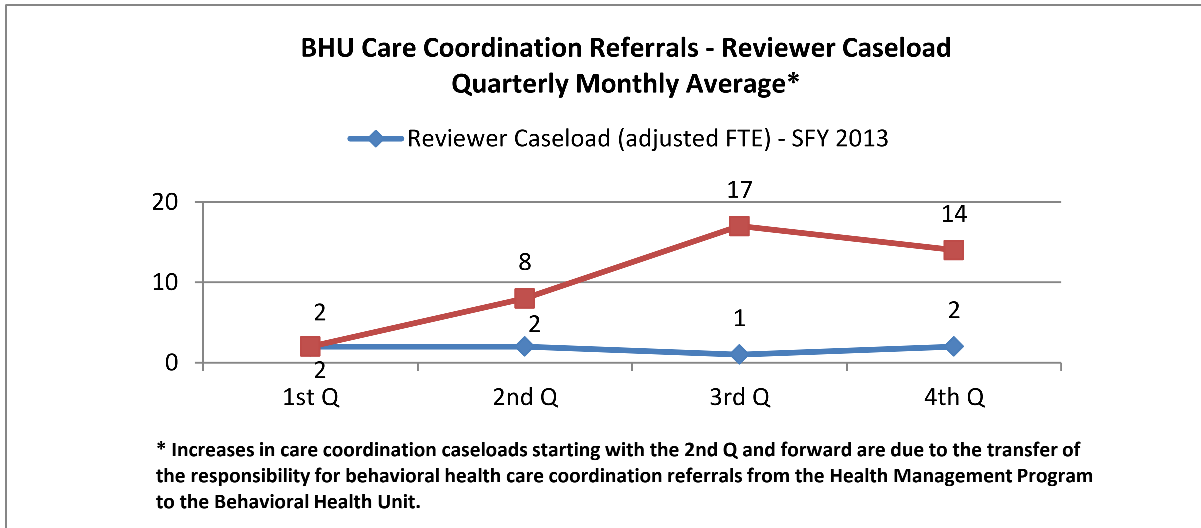
Behavioral Health Unit SFY 2014 *June 2013 – July 2014*	**1st QTR Monthly Average**	**2nd QTR Monthly Average**	**3rd QTR Monthly Average**	**4th QTR Monthly Average**
Total Prior Authorizations (Initials & Extensions)	3,253	3,266	3,319	3,370
Acute PAs	559	540	604	601
Residential Treatment PAs	2,366	2,356	2,371	2,407
Therapeutic Foster Care PAs	328	370	344	361
Reviewer PA Caseload	260	270	266	270



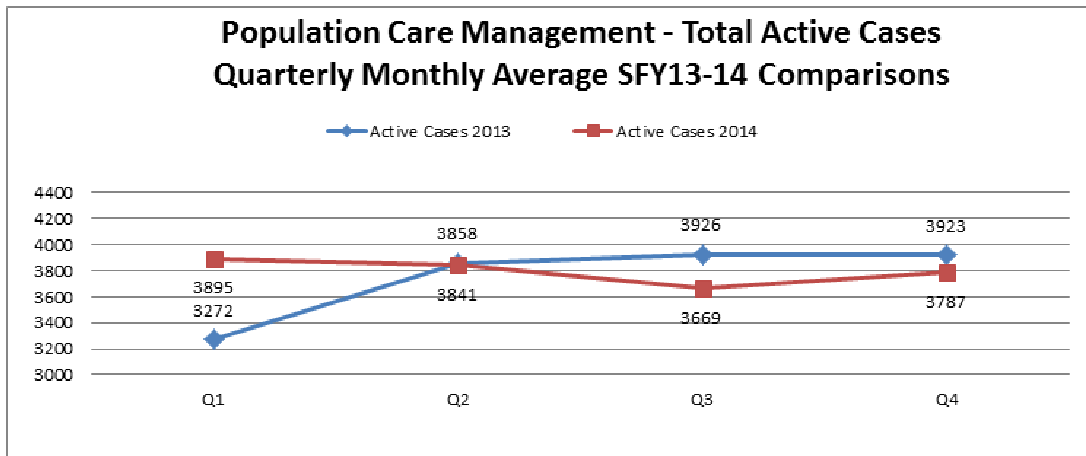


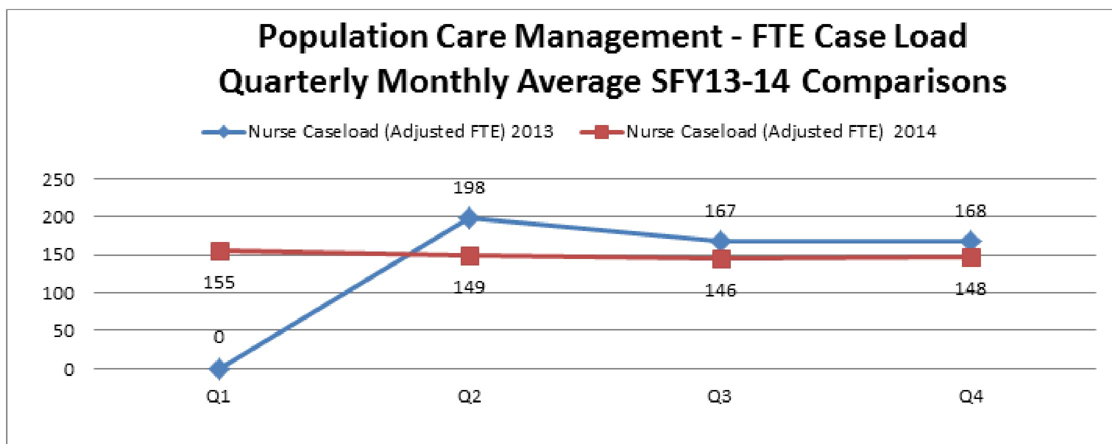
Behavioral Health Unit SFY 2014 *June 2013- July 2014*	**1st QTR Monthly Average**	**2nd QTR Monthly Average**	**3rd QTR Monthly Average**	**4th QTR Monthly Average**
Care Coordination Referrals	31	95	156	126
Reviewer CCR Caseload	2	8	17	14



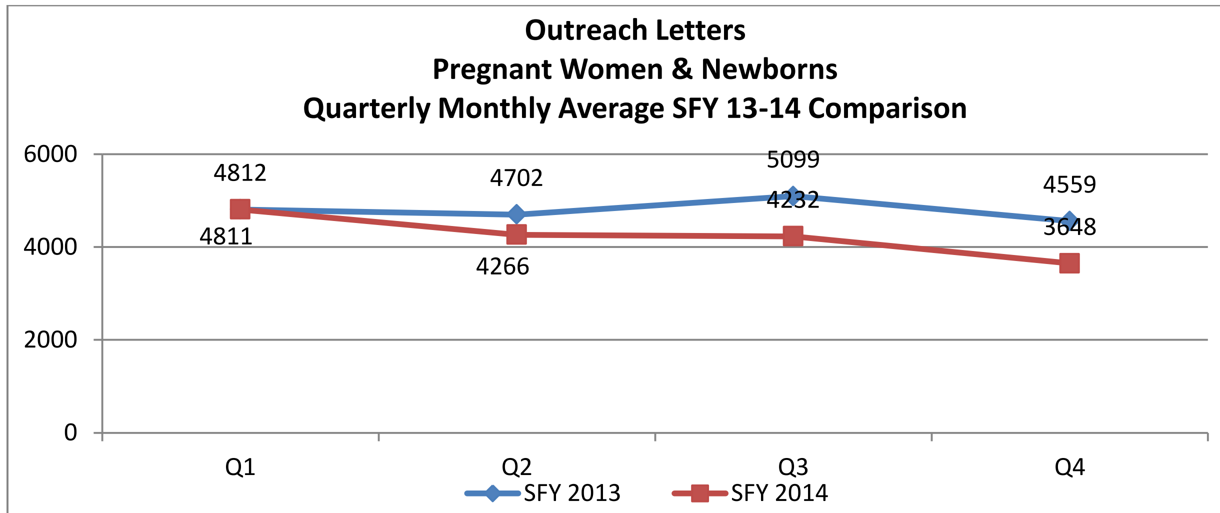


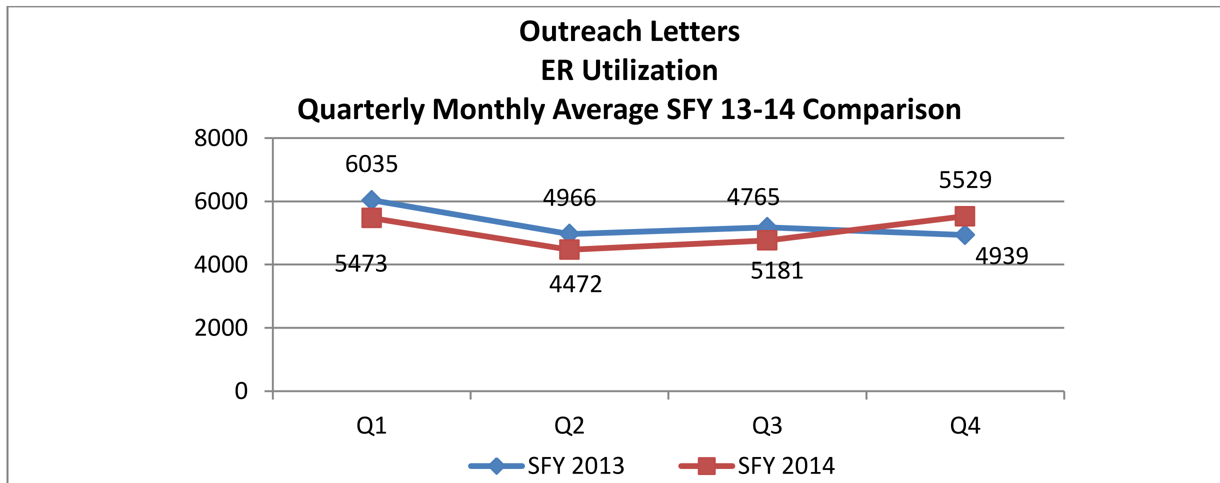
POPULATION CARE MANAGEMENT SFY 2014 - *July 2013 - June 2014*	**1st QTR Monthly Average**		**2nd QTR Monthly Average**		**3rd QTR Monthly Average**		**4thQTR Monthly Average**	
	New	Total	New	Total	New	Total	New	Total
Oklahoma Cares Cases	64	673	62	598	50	587	54	554
High-Risk and At-Risk OB Cases	263	509	259	505	243	445	255	409
Infant Mortality Reduction (Mom) Cases	167	711	133	651	154	613	140	664
Infant Mortality Reduction (Baby) Cases	201	1,835	183	1,818	179	1,856	150	1,864
Private Duty Nursing Cases	8	191	5	188	7	192	7	200
Social Service Referrals (Legislative Inquiry, Resource Referrals, Meals and Lodging Coordination)	103		75		77		85	
Onsite Evaluations (TEFRA, Private Duty Nursing, Living Choice)	60		71		61		72	



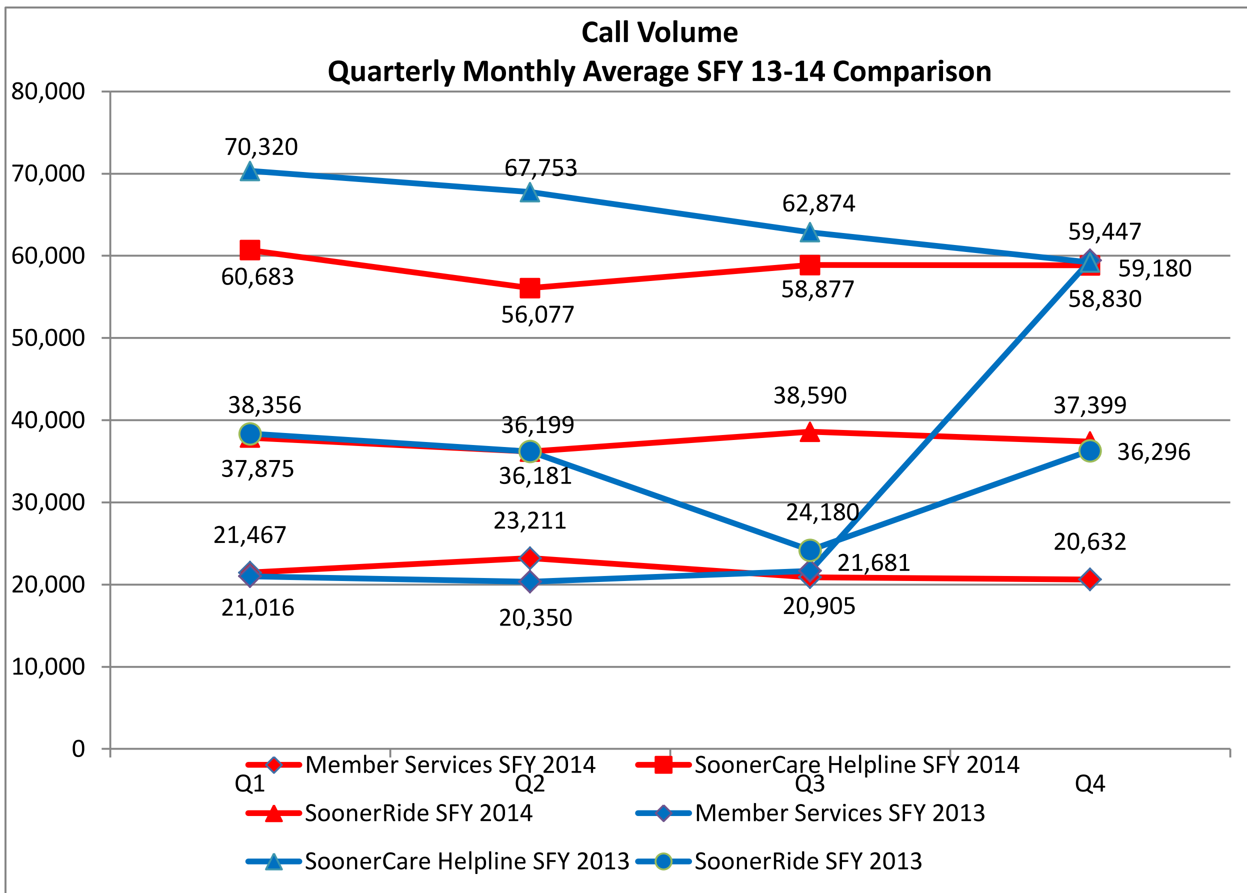


Member Services *SFY 2014* *July 2013-June 2014*	**1st QTR Monthly Average**	**2nd QTR Monthly Average**	**3rd QTR Monthly Average**	**4th QTR Monthly Average**
Electronic Newborn Enrollment	211	197	140	175
Patient Dismissal Request Reviewed	736	581	682	670
Outreach Letters Pregnant women & Newborns	4811	4266	4232	3648
Outreach Letters ER Utilization 2 or more visits	5473	4472	4765	5529



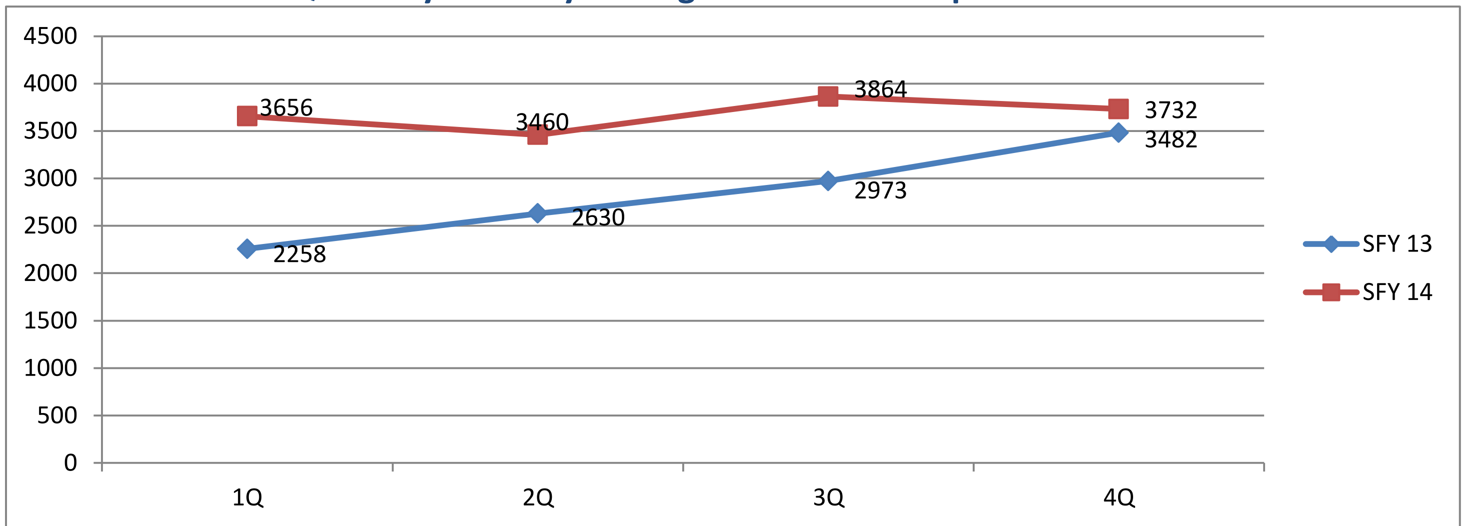


Member Services Call Volume SFY 2014 *July 2013- June 2014*	1st QTR Monthly Average	2nd QTR Monthly Average	3rd QTR Monthly Average	4th QTR Monthly Average
Member Services	21,467	23,211	20,905	20,632
SoonerCare Helpline**	60,683	56,077	58,877	58,830
SoonerRide^^	37,875	36,181	38,590	37,399
** Logisticare	^^ Maximus			

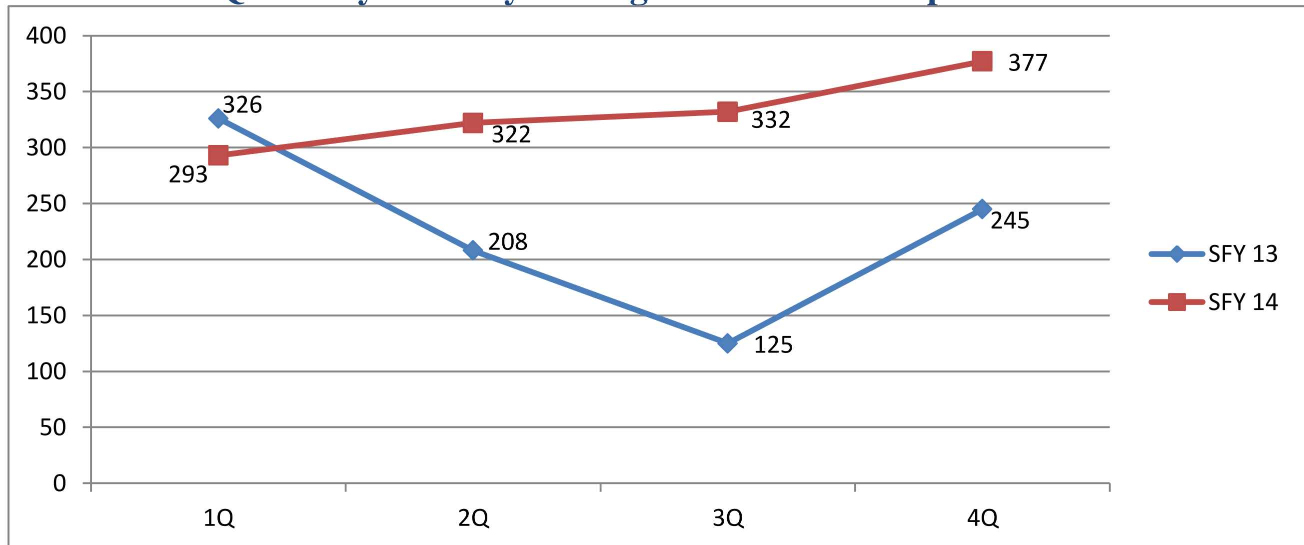


PROVIDER SERVICES **SFY 2014** *July 2013 – June 2014*	**1st QTR Monthly Average**	**2nd QTR Monthly Average**	**3rd QTR Monthly Average**	**4th QTR Monthly Average**
PCMH Enrollments	330	115	124	116
Dental Prior Authorizations	1,701	1,678	2002	1959
Provider On-Site Education/Recruitment Visits	293	322	332	377
Inpatient Notifications to PCPs	1,053	1,249	1168	990
Claim Reviews	1,211	1,207	913	975
No Show Letters	536	328	356	400
High ER Utilization Provider Education Hours	73	38	25	46
Phone Calls	3656	3460	3864	3732
BH Screening Visits Completed *started Dec 2013	0	8 total for Dec	125	75
Total Providers Educated *started Dec 2013	0	40 total for Dec	489	336

CTI – Total Phone Calls
Quarterly Monthly Average SFY 13-14 Comparison



Provider On-Site Education / Recruitment Visits
Quarterly Monthly Average SFY 13-14 Comparison



Oklahoma Health Care Authority

Flip Chart Action Plans 2014

Oklahoma Health Care Authority Strategic Planning Conference

The Strategic Planning Conference Agenda is available on line

Mission Statement

Our mission is to responsibly purchase state and federally funded health care in the most efficient and comprehensive manner possible; and to analyze and recommend strategies for optimizing the accessibility and quality of health care; and to cultivate relationships to improve the health outcomes of Oklahomans.

Goal #1 – Financing and Reimbursement

To responsibly purchase cost effective health care for members by maintaining appropriate rates and to continue to strengthen health care infrastructure

- Explore and consider Managed Care Organization (MCO) Models
- **HAN-Statewide & Satisfaction Surveys**
- **CPCi-Statewide**
- **Develop fully integrated HIE**
- **HIE Include Full Patient Profile – RX**
- **HAN Collect and Report Patient Outcomes-clinical**
- Reinstate provider rates to 100%
- Explore separating complex rehab services
- ER-Pool Intervention Ideas and Report
- Net-Educate and Increase Awareness
- Continue Monitoring Rate Change Impacts on Stakeholders

Goal #2 – Program Development

To ensure that medically necessary benefits and services are responsive to the health care needs of our members

- **Use of software for credentialing for providers**
- **E-Discovery**
- Impact of genetic testing in the future
- **Telemedicine-continued growth and potential abuse**
- Payment reform-Incentives for Outcomes
- CHIP Reauthorization
- Insure Oklahoma – ongoing for the future and adjusting to meet needs of Oklahoma workforce
- 1915c Mandates and case management
- 209b to SSI determination – eligibility for LTC
- Continued Internal Collaboration
- HR OB-allow for general OB (Change) requires notification
- **Collaboration with external partners is important (example: telemedicine, Baptist Hospital, stakeholders)**
- Implication of managed care, share success stories in this environment with legislature. Share administration cost studies.
- Look at services under EPSDT (eg. Incontinence supports) for Medical Necessity

Goal #3 – Personal Responsibility

To educate and engage members regarding personal responsibilities for their health services utilization, behaviors, and outcomes

- Impact of visit limits on access and out comes
- Make the healthy choice the easy choice
- BH Comorbidities-Identify, manage, treat
- Dental Visit Copay-refund after treatment done
- Rural Areas-Community Resource Awareness
- Communication c/o Patient and Provider
- Access to Care-PCMH and ER Use (Members can't get in timely, Why?)
- PCP selection and stability on panels
- Bi-Directional information sharing
- PCP Follow up with Patient "Do you understand?"
- Share info-PCP, Patient, Specialist
- Improved Patient Preparation for Visits
- Lifestyle changes: Motivate and educate
- Incentivize providers to educate members
- Depression: Identify, self-manage, treat
- Increase patient awareness of afterhours line
- After Hours line advice patients to go to ER
- Increase awareness of agency services
- Increase technology to communicate – Mobile Methods
- Develop Trust with members
- Further develop and expand motivational interviewing
- Consider social and behavioral environment
- Office appointment – instructions on why, how, and what to expect
- Monitor helpline wait times
- Fairview health survey tool-patient navigation ability
- Help members understand RN Triage Call protocols
- Educate members on difference between ER, urgent care, afterhours clinics
- Educate providers on referral to ER, Urgent Care, After Hours Clinics
- Make connection between patient, family, friends, neighbors (Tell Us your story)

Goal #4 – Satisfaction and Quality

To protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care

- ER Rosters More Timely
- **Additional money for HAN staff and IT**
- **Clinical/Medical Record Data**
- **Develop common toolset for PCP/HAN** (Build on HBA1c, screenings, asthma, RX, Opioids)
- Provider Portal
- Seek grants to provide money for additional QI
- Additional money and FTE for QI initiatives
- **Create dashboards in specific QI areas**
- Review our study on perception/use of toolkits by providers

Goal #5 – Eligibility and Enrollment

To provide and improve health care coverage to the qualified populations of Oklahoma

- **Continue investing in technological improvements**
- **Robust data from HIE-seek and add**
- **Continue single, streamlined eligibility access**
- **Build enterprise wide partnerships, coordinate and pool resources**
- **Continue and discuss exchanging of data**
- **Add all populations to OE-continue working on**

Goal #6 – Administration

To foster excellence and innovation in the administration of the OHCA

- **Mobile Messaging and Technology**
- **Technology linking data-vendor supported**
- **Modular approach to MMIS**
- **Replace DSS and CM Systems**
- **Cloud services-emphasize security**
- **IO technological enhancements**
- CM to additional populations
- Increase administration investments to ultimately lead to savings

Goal #7 – Collaboration

To foster collaboration among public and private individuals and entities to build a responsive health care system for Oklahoma

- **CPCi statewide**
- Continue IO-Market and develop version 2.0
- Add QI Areas-Obesity and Disparities
- **HAN-Statewide. Seek additional funding**
- Further BH integration
- **Develop HIE and data driven decisions**
- **Seeking increased partnership with Corrections**
- **Seeking increased partnership with Education**
- Prescription Drug Abuse-state plan
- Continued focus on obesity and tobacco use
- **Small business education: early childhood and health importance, IO and Certified Healthy Business**
- Physician Shortage
- Obesity-Epidemic Costs
- Culturally Focused outreach techniques
- **Private Philanthropy as Partner**
- **DHS and OJA (Childhood trauma)as partner**
- **United Way as partner**
- **Local Community Resources as Partner**

A face to face tribal consultation regarding the following proposed change was held Tuesday, July 1, 2014 in the Quartz Mountain conference room of the OHCA.

The following rule was posted for comment on August 6, 2014 through September 3, 2014.

14-17 Moving to an SSI Criteria State for Determining Medicaid Eligibility for Aged, Blind, and Disabled Individuals — Rules are amended to come into compliance with federal regulations regarding eligibility determinations for Aged, Blind, and Disabled (ABD) individuals applying for Medicaid services. OHCA is transitioning from a 209(b) State to the Supplemental Security Income (SSI) Criteria administrative option. This change includes amending current policy, the State Plan, and 1915(c) Home and Community Based Services Waivers pertaining to financial criteria for determining countable income and resources for ABD populations and matching that to current Social Security Administration regulations for persons receiving SSI.
Budget Impact: $10,988,587 total; $4,142,697 state.

A face to face tribal consultation regarding the following proposed change was held Tuesday, September 2, 2014 in the Board Room of the OHCA.

The following rule was posted for comment on August 14, 2014 through September 3, 2014.

14-14 HCBS Conflicts of Interest Compliance — Policy is revised to include all 1915(c) waiver programs to comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. These emergency changes are necessary as the regulation states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management services or develop the person centered service plan. Without the recommended changes, the State is out of compliance with CMS and may be in risk of losing federal funding.
Budget Impact: Budget Neutral

ODMHSAS Initiated

A face to face tribal consultation regarding the following proposed changes was held Tuesday, July 1, 2014 in the Quartz Mountain conference room of the OHCA.

The following rule was posted for comment on July 30, 2014 through September 3, 2014.

14-15 Behavioral Health Billable Hours — Rules are revised to limit the number of hours that outpatient behavioral health rendering providers can be reimbursed to 35 hours per week. Without the recommended revisions, ODMHSAS is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.
ODMHSAS Budget Savings: $14,335,949.42 total; $5,404,652 state.

The following rule was posted for comment on August 5, 2014 through September 3, 2014.

14-16 Health Homes — Rules are added to create coverage guidelines for Health Homes. Health Homes are created to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness.
ODHMSAS Budget Savings: $1,900,000 total; $716,300 state.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.2. Miscellaneous Personal property

(a) **Property used to produce goods and services.** Personal property necessary to perform daily activities or to produce goods for home consumption is excluded if the equity value does not exceed $6000. An equity value in excess of $6000 is a countable resource. The property does not have to produce a 6% annual return. The $6000 equity maximum includes all such resources in total and does not pertain to each item separately. Examples of property used to produce goods and services are tractors, wildcatting tools, mechanized equipment for gardening, livestock grown for home consumption, etc.

(b) **Cash savings and bank accounts.** Money on hand or in a savings account is considered as a countable resource. ~~The member's statement that he/she does not have any money on hand or on deposit is sufficient unless there are indications to the contrary. When there is information to the contrary or when the member does not have records to verify the amount on deposit, verification is obtained from bank records.~~ Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an Asset Verification System (AVS). Title 56, O.S., Section 1671 provides that financial records obtained for the purpose of establishing eligibility for assistance or services must be furnished without cost to the member or the Agency.

(1) Checking accounts may or may not represent savings. Current bank statements are evaluated with the member to establish what, if any, portion of the account represents savings. Any income which has been deposited during the current month is not considered unless it exceeds what is considered as ordinary maintenance expense for the month.

(2) Accounts which are owned jointly by the member and a person not receiving SoonerCare are considered available to the member in their entirety unless it can be established what part of the account actually belongs to each of the owners and the money is actually separated and the joint account dissolved. When the member is in a nursing facility and the spouse is in the home or if both are institutionalized, a joint bank account may be maintained with one-half of the account considered available to each.

(c) **Life insurance policies.** If the total face value of all life insurance policies owned by an individual is $1500 or less, the policies (both face value and cash surrender value) are excluded as resources. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(1) If the total face value of all policies owned by an individual exceeds $1500, the net cash surrender value of such policies must be counted as resources. Life insurance policies which do not provide a cash surrender value (e.g., term insurance) are not used in determining whether the total face value of all policies is over $1,500.

(2) The face value of a life insurance policy which has been assigned to fund a prepaid burial contract must be evaluated and counted according to the policy on burial funds or, if applicable, the policy on the irrevocable burial contract.

(3) The net cash surrender value of insurance (i.e., cash surrender value less any loans or unpaid interest thereon) usually can be verified by inspection of the insurance policies and documents in the member's

possession or by use of the OKDHS Form 08MP061E, Request to Insurance Company.

(4) Dividends which accrue and which remain with the insurance company increase the amount of resource. Dividends which are paid to the member are considered as income if the life insurance policy is not an excluded resource.

(5) If an individual has a life insurance policy which allows death benefits to be received while living, and the individual meets the insurance company's requirements for receiving such proceeds, the individual is not required to file for such proceeds. However, if the individual does file for and receive the benefits, the payment will be considered as income in the month it is received and countable as a resource in the following months to the extent it is available. The payment of such benefits is not considered a conversion of a resource because the cash surrender value of the insurance policy is still available to the individual. The individual is in effect, receiving the death benefits and not the cash surrender value.

(d) **Burial spaces.** The value of burial spaces for an individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources. "Burial spaces" means conventional grave sites, crypts, mausoleums, urns, and other repositories which are customarily and traditionally used for the remains of deceased persons. "Immediate family" means the individual's minor and adult children, including adopted children and step-children; and the individual's brothers, sisters, parents, adoptive parents, and the spouse of these individuals. Neither dependency nor living in the same household will be a factor in determining whether a person is an immediate family member. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(e) **Burial funds.** Revocable burial funds not in excess of $1500 are excluded as a resource if the funds are specifically set aside for the burial arrangements of the individual or the individual's spouse. Any amount in excess of $1500 is considered as a resource. Burial policies which require premium payments and do not accumulate cash value are not considered to be prepaid burial policies. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through the AVS.

(1) "Burial funds" means a prepaid funeral contract or burial trust with a funeral home or burial association which is for the individual's or spouse's burial expenses.

(2) The face value of a life insurance policy, when properly assigned by the owner to a funeral home or burial association, may be used for purchasing "burial funds" as described in (1) of this subsection. The $1500 burial fund exclusion must also be reduced by the face value of a life insurance policy for which a funeral provider has been made the irrevocable beneficiary, if the life insurance policy owner has irrevocably waived his or her right to, and cannot obtain, any cash surrender value the life insurance policy may generate.

(3) The burial fund exclusion must be reduced by the face value of life insurance policies owned by the individual or spouse; and amounts in an irrevocable trust or other irrevocable arrangement.

(4) Interest earned or appreciation on the value of any excluded burial funds is excluded if left to accumulate and become a part of the burial fund.

(5) If the member did not purchase his/her own prepaid burial, even if his/her money was used for the purchase, the member is not the "owner" and the prepaid burial funds cannot be considered a resource to him/her.

However, if the member's money was used by another to purchase the prepaid burial, the rules on transfer of property must be applied since the purchaser (owner) could withdraw the funds any time.

(f) **Irrevocable burial contract.** Oklahoma law provides that a purchaser (buyer) of a prepaid funeral contract may elect to make the contract irrevocable. The irrevocability cannot become effective until 30 days after purchase. For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner). In instances where the OKDHS Form 08MA084E, Management of Recipient's Funds, is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the member. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(1) If the irrevocable election was made prior to July 1, 1986, and the member received assistance on July 1, 1986, the full amount of the irrevocable contract is not considered a countable resource. This exclusion applies only if the member does not add to the amount of the contract. Interest accrued on the contract is not considered as added by the member. Any break in assistance will require that the contract be evaluated at the time of reapplication according to rules in (2) of this subsection.

(2) If the effective date for the irrevocable election or application for assistance is July 1, 1986, or later:

(A) the face value amount of an irrevocable burial contract cannot exceed $6,000 plus accrued interest through August 4, 1998~~.~~;

(B) the face value amount of an irrevocable burial contract cannot exceed $7,500 plus accrued interest for the period August 5, 1998, through October 31, 2009~~.~~;

(C) after November 1, 2009, state statute excludes the face value of an irrevocable burial contract, up to $10,000. This exclusion includes any combination of irrevocable contract, revocable prepaid account, designated account or cash value in life insurance policies not used to fund the burial policy, regardless of the face value, provided the cash value in policies and designated accounts does not exceed $1500. ~~When the amount exceeds $10,000, the member is ineligible for assistance.~~ After $10,000 is excluded, any remaining value of the irrevocable burial contract is counted against the resource limit. Accrued interest is not counted as a part of the $10,000 limit regardless of when it is accrued~~.~~; and

(D) the face value of life insurance policies used to fund burial contracts is counted towards the $10,000 limit.

(g) **Medical insurance.** If a member is covered by insurance other than SoonerCare, then SoonerCare is the payer of last resort and should not be ~~bill~~billed until all other payers have paid. If payment is made directly to the member, the member must reimburse OHCA up to the amount paid by SoonerCare. Any amount remaining after payment to OHCA is considered as an available resource.

317:35-5-41.3. Automobiles, pickups, and trucks

Automobiles, pickups, and trucks are considered in the eligibility determination for SoonerCare benefits. Verification of the member's countable resources held in bank accounts or at other financial institutions can be established through an AVS.

(1) **Exempt automobiles.** One automobile is excluded from counting as a resource~~ to the extent its current market value (CMV) does not exceed $4,500~~. ~~The CMV in excess of $4,500 is counted against the resource limit;~~

~~or exempt one automobile, pickup or truck per family regardless of the value if it is verified that the car is used:~~

~~(A) for medical services 4 times a year to obtain either medical treatment or prescription drugs; or~~

~~(B) for employment purposes; or~~

~~(C) especially equipped for operation by or transportation of a handicapped person.~~

(2) **Other automobiles.** The equity in other automobiles, pickups, and trucks is considered as a countable resource. The current market value, less encumbrances on the vehicle, is the equity. Only encumbrances that can be verified are considered in computing equity.

(A) The market value of each year's make and model is established on the basis of the "Avg. Trade In" value as shown in the current publication of the National Automobile Dealers Association (NADA) on "Cars, Trucks, and Imports".

(B) If a vehicle's listing has been discontinued in the NADA book, the household's estimate of the value of the vehicle is accepted unless the worker has reason to believe the estimate is incorrect.

(C) The market value of a vehicle no longer operable is the verified salvage value.

(D) In the event the member and worker cannot agree on the value of the vehicle, the member secures written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals or between the book value and one or more of these appraisals, the worker and the member jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current values and who is acceptable to both the member and the worker.

317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding SSI) or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

(2) If a husband and wife are living in their own home, the couple's total income and/or resource is divided equally between the two cases. If they both enter a nursing facility, their income and resources are considered separately.

(3) If only one spouse in a couple is eligible and the couple ceases to live together, only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live together are considered.

(4) In calculating monthly income, cents are included in the computation Until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1 - 49 cents is rounded down, and 50 - 99 cents is rounded up). For example, an individual's

weekly earnings of $99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ($99.90 x 4.3 = $429.57 rounds to $430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify OASDI benefits.

(b) **Income disregards.** In determining need, the following are not considered as income:

(1) ~~The coupon allotment under the Food Stamp Act of 1977~~The value of Supplemental Nutrition Assistance Program (food stamps) received;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish loan as bona fide includes:

(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.

(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.

(C) Proceeds of a loan secured by an exempt asset are not an asset;

(5) One-third of child support payments received on behalf of the disabled minor child;

(6) Indian payments (including judgment funds or funds held in trust) distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;

(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;

(8) Title III benefits from State and Community Programs on Aging;

(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the national School Lunch Act;

(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(13) Reimbursements from an employer for out-of-pocket expenditures and

allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;
(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;
(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments, or utilities;
(18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;
(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments, and disaster assistance organizations;
(22) Income of a sponsor to the sponsored eligible alien;
(23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;
(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);
(25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;
(26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;
(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);
(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);
(30) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; ~~and~~
(31) Wages paid by the Census Bureau for temporary employment related to Census activities~~.~~;
(32) Income tax refunds;

(33) Home energy assistance;
(34) Food or shelter based on need provided by nonprofit agencies;
(35) Money someone else spends to pay your expenses for items other than food or shelter (e.g., someone pays for your telephone or medical bills);
(36) Earnings up to $1,750 per month to a maximum of $7,060 per year (effective January 2014) for a student under age 22;
(37) The cost of impairment-related work expenses for items or services that a disabled person needs in order to work; and
(38) The first $2,000 of compensation received per calendar year for participating in certain clinical trials.

(c) **Determination of income.** The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.

(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

(3) Some of the more common income sources to be considered in determining eligibility are as follows:

(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.

(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:

(I) seeing the member's award letter or warrant;

(II) obtaining a signed statement from the individual who cashed the warrant; or

(III) by using BENDEX and SDX.

(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Form 08AX011E.

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:

(I) **Nursing facility care.** VA Aid and Attendance or Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not

affect the income eligibility or the vendor payment of the member.

(II) **Own home care.** The actual amount of VA Aid and Attendance payment paid for an attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to $90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to $90 per month. None of the $90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the $90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for the mentally retarded or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) **Lump sum payments.**

(i) Any income received in a lump sum (with the exception of SSI lump sum) covering a period of more than one month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 18), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, retroactive OASDI, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

(iii) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.

(iv) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.

(D) **Income from capital resources and rental property.** Income from capital resources can be derived from rental of a house, rental from

land (cash or crop rent), leasing of minerals, life estate, homestead rights, or interest.

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. When the difference between the gross and net income represents a production or severance tax (e.g., most oil royalties are reduced by this tax), the OHCA only uses the net figure when determining income eligibility. The production or severance tax is the cost of producing the income, and, therefore, is deducted from the gross income. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two ~~month's~~months' royalty income is averaged to compute countable monthly income.

(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will verify whether or not the income is from self-employment. Otherwise, income received from ~~rent~~rental property is treated as unearned income.

(iii) When ~~property rental~~rental property is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the member is considered as income.

(E) **Earned income/self-employment.** The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission, or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise. An exchange of labor or services~~;~~, e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with SoonerCare benefits.

(i) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

(ii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business ~~expense~~expenses and appropriate earned income disregards.

(iii) Self-employment income is determined as follows:

(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount, as well as the allowable deductions, are the same as can be claimed under the Internal Revenue code for tax purposes.

(II) Self-employment income which represents a household's annual support is prorated over a 12- month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is

averaged over a 12-month period if the income represents the farmer's annual support.

(III) If the household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise is averaged over the period of time the business has been in operation to establish the monthly income amount.

(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.

(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation (these expenses are accounted for by the work related expense deduction given in OAC 340:10-3-33(1)).

(iv) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are then applied to establish countable earned income.

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of $10 or less per month or $30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two ~~month's~~months' income, if possible, to determine income eligibility. Less than two ~~month's~~months' income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(i) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(ii) **Weekly.** Income received weekly is multiplied by 4.3.

(iii) **Twice a month.** Income received twice a month is multiplied by 2.

(iv) **Biweekly.** Income received every two weeks is multiplied by 2.15.

(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.

(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.

(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.

(d) **Computation of income.**

(1) **Earned income or unearned income.** The general income exclusion of $20 per month is allowed for earned or unearned income, unless the unearned income is SSP, on the combined ~~earned~~ income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income. The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered.

~~(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) of this subsection if there are ineligible minor children.~~

~~(3)~~(2) **Countable income.** The countable income is the sum of the earned income ~~after exclusions~~ and the total gross unearned income after exclusions.

~~(4)~~(3) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

(A) ~~A~~An intellectually disabled child living in the home who is ineligible for SSP due to the deeming process may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program as outlined in OAC 317:35-9- 5.

(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.

~~(5)~~(4) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.

~~(6)~~(5) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:

(A) Each ineligible child's allocation (OKDHS Form 08AX001E, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.

(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.

(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

~~(7)~~(6) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

(A) transportation to and from work;
(B) job performance; and
(C) job improvement.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-14. Description of services

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

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or skilled nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Medically Fragile Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(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 317:50-1-15(1)(A)that only a Medically Fragile case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or

supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(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 member served.

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

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

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

(2) **Institutional Transition Services.**

(A) Institutional Transition Case Management Services are Services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.
(C) Transition Case Management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **Respite.**
(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. 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 member's home.
(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.
(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(4) **Environmental Modifications.**
(A) Environmental Modifications are physical adaptations to the home, required by the member'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 member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

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

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

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

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

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

(7) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty

nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.
(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.
(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:
(I) the member's general health, functional ability and needs and/or
(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.
(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:
(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;
(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;
(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;
(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition

Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

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

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

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or

injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

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

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

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

(12) **Respiratory Therapy Services.**
(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.
(B) Respiratory Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice Services.**
(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. Medically Fragile Waiver Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal

illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile Hospice services.

(C) 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 member or member's family.

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

(A) Medically Fragile Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize

physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

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

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

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

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

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

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

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

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

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

care.

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

(17) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

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

(i) residence in the Self-Directed services approved area;

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

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

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

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12

months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

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

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

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

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

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

(iv) the member abuses or exploits their employee; or

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

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

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

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA 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.

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

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

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

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

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

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

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted

with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

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

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

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

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

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

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

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

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less

than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

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

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

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

(B) These goods and services are purchased from the self-directed budget.

SUBCHAPTER 3. My Life, My Choice

317:50-3-14. Description of services

Services included in the My Life, My Choice Waiver Program are as follows:

(1) **Case Management.**

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

health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet My Life, My Choice Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(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 317:50-3-14(1)(A) that only a My Life, My Choice case manager because of skill, training or authority, can perform on behalf of a member;

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

(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 member served.

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

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

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

(2) **Institutional Transition Services.**

(A) Institutional Transition Case Management Services are Services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.

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

member is discharged from the institution.

(3) **Respite.**

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

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

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

(4) **Environmental Modifications.**

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

(B) All services require prior authorization.

(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 members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit

to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

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

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

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

(7) **Nursing.**

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

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical

services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the My Life, My Choice Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

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

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

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

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

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

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

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

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the

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

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

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

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

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

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

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and

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

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

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

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

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

(12) **Respiratory Therapy services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and

feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(13) **Hospice services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. My Life, My Choice Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

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

medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for My Life, My Choice 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 member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive My Life, My Choice Hospice services.

(C) 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 member or member's family.

(14) **My Life, My Choice Waiver Personal Care.**

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

(B) My Life, My Choice Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) My Life, My Choice 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 approved plan of care.

(15) **Assisted Living Services.**
(A) Assisted Living Services are personal care and supportive services that are furnished to the member who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security.
(B) Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluation, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordination of transportation to and from medical appointments.
(C) Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the member as determined throughout individualized assessment and documented on the member=s service plan.
(D) Payment is not made for 24 hour skilled care.
(16) **Adult Day Health.** Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member.
(17) **Assistive Technology.** Assistive technology enables the member to maintain or increase functional capabilities. Assistive technology devices are in addition to equipment and supplies readily available through traditional State Plan services and exclude items that are not of direct medical or remedial benefit to the member. Assistive technology includes the purchase, rental, customization, maintenance and repair of such devices.
(18) **Audiology Treatment and Evaluation.** Services include evaluation, treatment and consultation related to auditory functioning and are intended to maximize the member's hearing abilities.
(19) **Agency Companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;
(20) **Dental services.** Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed $1,000

per plan year of care. These services may include:
(A) oral examination;
(B) bite-wing x-rays;
(C) prophylaxis;
(D) topical fluoride treatment;
(E) development of a sequenced treatment plan that prioritizes:
(i) elimination of pain;
(ii) adequate oral hygiene; and
(iii) restoration or improved ability to chew;
(F) routine training of member or primary caregiver regarding oral hygiene; and
(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(21) **Family Training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(22) **Family Counseling.** Family counseling helps to develop and maintain healthy, stable relationships among all family members in order to support meeting the needs of the member. Emphasis is placed on the acquisition of coping skills by building upon family strengths. Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home. Services are intended to maximize the member/family's emotional/social adjustment and well-being. All family counseling needs are documented in the member's plan of care. Individual counseling cannot exceed 400, 15-minute units per plan of care year. Group counseling cannot exceed 225, 30-minute units per plan of care year. Case Managers assist the member to identity other alternatives to meet identified needs above the limit.

(23) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider.

Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

(24) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(25) **Independent Living Skills training.** Independent living skills training is a service to support the individual's self-care, daily living, adaptive skills and leisure skills needed to reside successfully in the community. Services are provided in community based settings in a manner that contributes to the individual_s independence, self-sufficiency, community inclusion and well-being. This service is intended to train members with significant cognitive problems living skills such as selecting clothing, dressing, and personal shopping.

(26) **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 member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For a My Life, My Choice Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

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

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

(iv) has a health and safety plan detailing the

interventions beyond the PERS to assure the member's health and safety in his/her home;
(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,
(vi) the service avoids premature or unnecessary institutionalization of the member.
(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the My Life, My Choice approved plan of care.

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

(28) **Psychiatry.** Psychiatry provides outpatient psychiatric services provided by a licensed psychiatrist and will be comprised of diagnosis, treatment and prevention of mental illness. These services will also include review, assessment and monitoring of psychiatric conditions, evaluation of the current plan of treatment and recommendations for a continued and/or revised plan of treatment and/or therapy, including required documentation. Psychiatrists may provide instruction and training to individuals, family members, case management staff and/or provider staff in recognition of psychiatric illness and adverse reactions to medications.

(29) **Psychological services.** Psychological services include evaluation, psychotherapy, consultation and behavioral treatment. Services are provided in any community setting as specified in the member's service plan. Services are intended to maximize the member's psychological and behavioral well-being. Services are provided in both individual and group (8 person maximum) formats. The OHCA Care Management Team will review service plans to ensure that duplication of services does not occur.

(30) **Pharmacological Therapy Management.** Pharmacological Therapy Management will utilize individual case management techniques for qualifying waiver members. Medication profiles will be reviewed for therapeutic duplication, drug-drug interactions, drug-disease interactions, contraindications, appropriate dosing and other measures of therapeutic

appropriateness using principles of evidence-based medicine from peer-reviewed literature. Members are selected for therapy management based on medication utilization, or if they are referred to the program by a care manager.

(31) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRice NET services is located at 317:30-5-326.

(32) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

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

(i) residence in the Self-Directed services area;

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

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

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service

planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

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

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

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

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

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

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

(iv) the member abuses or exploits their employee; or

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

(vi) the member, even with Case Manager and Financial

Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

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

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA 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.

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

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

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

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within

Individual Budget Allocation limits, wages to be paid for the work;

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

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

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

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

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

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

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

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

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

(i) The Individual Budget Allocation (IBA) Expenditure

Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

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

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

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

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

(B) These goods and services are purchased from the self-directed budget.

SUBCHAPTER 5. SOONER SENIORS

317:50-5-14. Description of services

Services included in the Sooner Seniors Waiver Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Sooner Seniors Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(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 317:50-5-14(1)(A) that only a Sooner Seniors case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary

business overhead costs have been included in the reimbursement rate for billable activities.

(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 member served.

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

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

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

(2) **Institutional Transition Services.**

(A) Institutional Transition Case Management Services are services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Waiver Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and

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

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

(3) **Respite.**

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

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

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

(4) **Environmental Modifications.**

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

(B) All services require prior authorization.

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

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

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

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

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

(7) **Nursing.**

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

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

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

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

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

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

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

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and

monitoring due to a minimal level of disorientation or confusion;
(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;
(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;
(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

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

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

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

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

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community.

Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

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

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

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

written reports or record documentation.

(12) **Respiratory therapy services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(13) **Hospice services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. Sooner Seniors Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost

limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Sooner Seniors 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 member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Sooner Seniors Hospice services.

(C) 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 member or member's family.

(14) **Sooner Seniors Waiver Personal Care.**

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

operation/maintenance of equipment of a technical nature.

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

(C) Sooner Seniors 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 approved plan of care.

(15) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to the member who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security.

(B) Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluation, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordination of transportation to and from medical appointments.

(C) Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the member as determined throughout individualized assessment and documented on the member=s service plan.

(D) Payment is not made for 24 hour skilled care.

(16) **Adult Day Health.** Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member.

(17) **Agency companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;

(18) **Dental services.** Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed $1,000 per plan year of care. These services may include:

(A) oral examination;

(B) bite-wing x-rays;

(C) prophylaxis;
(D) topical fluoride treatment;
(E) development of a sequenced treatment plan that prioritizes:
(i) elimination of pain;
(ii) adequate oral hygiene; and
(iii) restoration or improved ability to chew;
(F) routine training of member or primary caregiver regarding oral hygiene; and
(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(19) **Family training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(20) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

(21) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(22) **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 member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For a Sooner Seniors Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

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

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

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

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

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

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

(24) **Pharmacological Therapy Management.** Pharmacological Therapy Management will utilize individual case management techniques for qualifying waiver members. Medication profiles will be reviewed for therapeutic duplication, drug-drug interactions, drug-disease interactions, contraindications, appropriate dosing and other measures of therapeutic appropriateness using principles of evidence-based medicine from peer-reviewed literature. Members are selected for

therapy management based on medication utilization, or if they are referred to the program by a care manager.

(25) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRide NET services is located at 317:30-5-326.

(26) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

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

(i) residence in the Self-Directed services area;

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

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

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced

Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

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

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

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

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

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

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

(iv) the member abuses or exploits their employee; or

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

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation;

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

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA 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.

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

(i) recruits, hires and, as necessary, discharges the PSA and APSA;
(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA_s personnel file;
(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,
(v) provides tools and materials for work to be accomplished.

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;
(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;
(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;
(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Respite or Personal Services Assistant or Advanced Personal Services Assistant; and

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

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

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

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less

than expenditures for equivalent services using agency providers.
(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.
(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and service plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(c) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.

(d) All outpatient BH services must be provided following established medical necessity criteria. Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(e) Services to nursing facility residents. Reimbursement is not allowed for outpatient behavioral health services provided to members residing in a nursing facility. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the rate paid to the nursing facility for the member's care.

(f) In addition to individual service limitations, reimbursement for outpatient behavioral health services is limited to 35 hours

per rendering provider per week. Services not included in this limitation are:
(1) Assessments;
(2) Testing;
(3) Service plan development; and
(4) Crisis intervention services.

PART 25. PSYCHOLOGISTS

317:30-5-276. Coverage by category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** Coverage for adults by a psychologist is limited to Bio-Psycho-Social Assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: Depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

(1) Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one PDIE is allowable per provider per member. If there has been a break in service over a six month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the psychologist. Sessions typically involve members who have other individuals legally responsible for their care (i.e.

minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of a SoonerCare eligible child as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six patients for children four years of age up to the age of 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of a SoonerCare eligible child four years of age or older as a specifically identified component of an individual treatment

plan. Multi-family group therapy size is limited to eight family units.
(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.
(6) Health and Behavior codes - behavioral health services are available only to chronically and severely medically ill children.
(7) Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.
(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. A maximum of 35 hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four week average. Case Management services are considered an integral component of the behavioral health services listed above.
(9) A child who is being treated in an acute psychiatric inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only.
(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or psychological

testing unless allowed by the OHCA or its designated agent.
(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.
(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.
(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** Coverage for adults by a LBHP is limited to Bio-Psycho-Social Assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

(1) Bio-Psycho-Social and Level of Care Assessments.

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for Children's Level of Care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual

psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated

patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six for ages four up to 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to eight sessions/units per month. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. A maximum of 35 hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four week average. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive

individual, group or family counseling or testing unless allowed by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 22. HEALTH HOMES

317:30-5-250. Purpose

Health Homes for Individuals with Chronic Conditions are created to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. The purpose of the Health Home is to improve the health status of SoonerCare members with Serious Mental Illness or Serious Emotional Disturbance by promoting wellness and prevention and to improve access and continuity in health care for these members by supporting coordination and integration of primary care services in specialty behavioral health settings.

317:30-5-251. Eligible providers

(a) **Agency requirements.** Providers of Health Home (HH) services are responsible for providing HH services to qualifying individuals within the provider's specified service area. Qualifying providers must be:

(1) Certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center under OAC 450:17; or

(2) Accredited as a provider of outpatient behavioral health services from one of the national accrediting bodies; or

(3) Certified by ODMHSAS as a Mental Illness Service Program pursuant to OAC 450:27; or

(4) Certified by ODMHSAS as a Program of Assertive Community Treatment (PACT) pursuant to OAC 450:55.

(5) In addition to the accreditation/certification requirements in (1) - (4), providers must also have provider specific credentials from ODMHSAS for Health Home Services (OAC 450:17; OAC 450:27; OAC 450:55).

(b) **Health Home team.** Health Homes will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower persons toward self-management and coordinate the individual's varied healthcare needs. HH teams will vary in size depending on the size of the member panel and acuity of members. HH team composition will vary slightly between providers working with adults and children.

(1) Health Homes working with adults with Serious Mental Illness (SMI) will utilize a multidisciplinary team consisting of the following:

(A) Project Director;

(B) Nurse Care Manager;
(C) Consulting Primary Care Practitioner (PCP);
(D) Psychiatric Consultant (317:30-5-11);
(E) Certified Behavioral Health Case Manager (CM)(OAC 450:50; 317:30-5-595);
(F) Wellness Coach/Peer Support Specialist (OAC 450:53; 317:30-5-240.3); and
(G) Administrative support.

(2) In addition to the individuals listed in (1)(A) through (G) above, teams working with adults with SMI (PACT teams only) will also have at least one of the following team members:
(A) Licensed Behavioral Health Professional (317:30-5-240.3);
(B) Substance abuse treatment specialist (Licensed Alcohol and Drug Counselor (LADC) or Certified Alcohol and Drug Counselor (CADC); or
(C) Employment specialist.

(3) Health Homes working with children with Serious Emotional Disturbance (SED) will utilize a multidisciplinary team consisting of the following:
(A) Project Director;
(B) Nurse Care Manager;
(C) Consulting Primary Care Practitioner (PCP);
(D) Psychiatric Consultant (317:30-5-11);
(E) Family Support Provider (317:30-5-240.3);
(F) Youth/Peer Support Specialist (OAC 450:53; 317:30-5-240.3);
(G) Health Home specialist; and
(H) Administrative support.

317:30-5-252. Covered Services

Health Home services are covered for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) as set forth in this Section unless specified otherwise, and when provided in accordance with a documented care plan. Coverage includes the following services:

(1) **Comprehensive Care Management.**
(A) **Definition.** Comprehensive care management services consist of developing a Comprehensive Care Plan to address needs of the whole person and involves the active participation of the Nurse Care Manager, certified Behavioral Health Case Manager, Primary Care Practitioner, the Health Home clinical support staff with participation of other team members, family and caregivers.
(B) **Service requirements.** Comprehensive care management services include the following, but are not limited to:

(i) Identifying high-risk members and utilizing member information to determine level of participation in care management services;
(ii) Assessing preliminary service needs; participating in comprehensive person-centered service plan development; responsible for member physical health goals, preferences and optimal clinical outcomes;
(iii) Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
(iv) Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines; and
(v) Developing and disseminating reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery and cost.

(C) **Qualified professionals.** Comprehensive care management services are provided by a health care team with participation from the client, family and caregivers, consisting of the following required professionals and paraprofessionals:
(i) Nurse Care Manager;
(ii) Certified Behavioral Health Case Manager; and
(iii) Primary Care Practitioner.

(2) **Care Coordination.**
(A) **Definition.** Care coordination is the implementation of the Comprehensive Care Plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.
(B) **Service requirements.** Care coordination services include the following, but are not limited to:
(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals and Psychiatric Residential Treatment Facilities (PRTFs);
(ii) Ensuring integration and compatibility of mental health and physical health activities;
(iii) Providing on-going service coordination and link members to resources following training when applicable;
(iv) Tracking completion of mental and physical health goals in member's Comprehensive Care Plan;
(v) Coordinating with all team members to ensure all objectives of the Comprehensive Care Plan are progressing;
(vi) Appointment scheduling;

(vii) Conducting referrals and follow-up monitoring;
(viii) Participating in hospital discharge processes; and
(ix) Communicating with other providers and members/family.

(C) **Qualified professionals.** Team members are responsible to ensure implementation of the Comprehensive Care Plan, which includes mental health goals, physical health goals, and other life domain goals for achievement of clinical outcomes. Care coordination services are provided by a physician-led team which includes the following professionals:
(i) Nurse Care Manager;
(ii) Licensed Practical Nurse (LPN); and
(iii) Certified Behavioral Health Case Managers.

(3) **Health Promotion.**

(A) **Definition.** Health promotion consists of providing health education specific to the member's chronic condition.

(B) **Service requirements.** Health promotion will minimally consist of the following, but is not limited to:
(i) Providing health education specific to member's condition;
(ii) Developing self-management plans with the member;
(iii) Providing support for improving social networks and providing health promoting lifestyle interventions including:
(I) Substance use prevention;
(II) Smoking prevention and cessation;
(III) Obesity reduction and prevention;
(IV) Nutritional counseling; and
(V) Increasing physical activity.

(C) **Qualified professionals.** Health promotion services must be provided by the Primary Care Practitioner, Registered Nurse Care Manager (or LPN within full scope of practice) and the Wellness Coach/Health Home specialist at the direction of the Project Director.

(4) **Comprehensive Transitional Care.**

(A) **Definition.** Care coordination services for comprehensive transitional care are designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.

(B) **Service requirements.** In conducting comprehensive transitional care, the Nurse Care Manager and the case manager will work as co-leads. The duties of the Nurse Care Manager or the case manager include, but are not limited to the following:

(i) Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home members;

(ii) Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and

(iii) Motivate hospital staff to notify the Health Home staff of such opportunities.

(5) **Individual and Family Support Services**

(A) **Definition.** Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self- manage their care, and facilitate participation in the ongoing revision of their Comprehensive Care Plan.

(B) **Service requirements.** Individual and family support services include, but are not limited to:

(i) Teaching individuals and families self-advocacy skills;

(ii) Providing peer support groups;

(iii) Modeling and teaching how to access community resources;

(iv) Assisting with obtaining and adhering to medications and other prescribed treatments; and

(v) Identifying resources to support the member in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.

(C) **Qualified individuals.** Individual and family support service activities must be provided by one of the following:

(i) Wellness Coaches/Recovery support specialist/Health Home specialist; or

(ii) Care coordinators; or

(iii) Family Support Providers.

(6) **Referral to Community and Social Support Services**

(A) **Definition.** Provide members with referrals to community and social support services in the community.

(B) **Service requirements.** Providing assistance for members to obtain and maintain eligibility for the following services as applicable, including but not limited to:

(i) Healthcare;

(ii) Disability benefits;

(iii) Housing;
(iv) Transportation;
(v) Personal needs; and
(vi) Legal services.

(C) **Limitations.** For members with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

317:30-5-253. Reimbursement

(a) In order to be eligible for payment, HHs must have an approved Provider Agreement on file with OHCA. Through this agreement, the HH assures that OHCA's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed annually with each provider.

(b) A Health Home may bill up to three months for outreach and engagement to a member attributed to but not yet enrolled in a Health Home. The reimbursement for outreach and engagement is limited to once per month and is not reimbursable in the same month that the HH receives reimbursement for qualified HH services.

(c) The HH will be reimbursed a monthly care coordination payment upon successful submission of a claim for one or more of the covered services listed in 317:30-5-251.

317:30-5-254. Limitations

(a) Children/families for whom case management services are available through OKDHS/OJA staff are not eligible for concurrent Health Home services.

(b) The following services will not be reimbursed separately for individuals enrolled in a Health Home:

(1) Targeted case management;
(2) Service Plan Development, moderate and low complexity;
(3) Medication training and support;
(4) Peer recovery support;
(5) Peer to Peer support (Family support);
(6) Medication management and support and coordination linkage when provided within a Program of Assertive Community Treatment (PACT);
(7) Medication reminder;
(8) Medication administration;
(9) Outreach and engagement.

September 2014 MAC
Proposed Rules and Waiver Amendment Summaries

Information Only

The following are summaries of proposed rules and waiver amendments. These proposals are still in the research stage and are not final. As such, some of the proposals you see here may not advance beyond the research stage. OHCA prepared this document to give members of the MAC a preview of rules, waivers, and state plan revisions. This document is for informational purposes only.

Rule Changes

Private Duty Nursing — Private Duty Nursing (PDN) rules will be amended to reflect initial determination and renewals for services must be determined by a physician. Additionally, physicians will also be responsible for scoring the acuity grid utilized to determine medical necessity. Nurses' responsibility would be to gather, summarize, and present the individual cases to the physicians.

Certified Nursing Aide (CNA) Training — CNA rules will be amended to discontinue reimbursing schools and instead directly reimburse the students on a pro rata basis for each quarter they are employed in a nursing facility. The amount paid will also be changed.

Allergy Services and Immunotherapy — Rules will be amended to add regulations and limitations on allergy services and immunotherapy utilization. Current policy has no controls on these services other than medical necessity.

Referrals for Specialty Services — Policy is revised to remove language regarding the inclusion of referral documentation in members' medical records. The use of electronic referrals will replace the need of paper documentation.

Wavier Amendments

Zero Copay for Preferred Generic Drugs — The Zero Copay for Preferred Generic Drugs program will no longer be available for Home and Community Based Services waiver members effective February, 2015. Waiver members acquiring generic drugs will be required to provide a nominal copay. The copays currently required for waiver members will be applied to the group of preferred generic drugs.

1915c Waivers Operational Functions — The OHCA is exploring options to transition the operational functions of its internal 1915c Waiver services and responsibilities. The three (3) internal waivers include: (a) My Life My Choice; (b) Sooner Seniors and (c) Medically Fragile. In total, these waivers serve approximately one hundred sixty (160) members. Factors under consideration and exploration to transition the operational waiver responsibilities include, but are not limited to, contracting with an external entity to perform all operational services or transitioning some or all members into other existing waivers as applicable.