OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
January 15, 2015
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions: Chairman, Steven Crawford, M.D.

II. Public Comments (2 minute limit)

III. MAC Member Comments/Discussion

IV. **Action Item**: Approval of Minutes of the November 20, 2014 Medical Advisory Committee Meeting

V. OHCA response to Oklahoma Dental Association comments: Sylvia Lopez, Chief Medical Officer

VI. Financial Report SFY 15 Five Months: Gloria Hudson, Director of General Accounting

VII. SoonerCare Operations Update: Kevin Rupe, Chief Operation Officer

VIII. Legislative Update

A. Budget Request Detail: Carter Kimble, Director of Governmental Relations

B. Abstract - HB 2906- ER Utilization Study: Jacob Booth, Planning Coordinator III

IX. Presentation and Discussion on Proposed Rule Changes: Demetria Bennett, Policy Development Coordinator

A. 14-09 SoonerCare Choice Policy Change

B. 14-18 Policy Change for State Plan Personal Care Services

C. 14-24 340B Drug Discount Program

D. 14-26 Certified Nursing Aide (CNA) Training

E. 14-27 Private Duty Nursing services

F. 14-29A&B Lock-in Policy Clean Up

G. 14-35 DMEPOS Free Choice

H. 14-41 Referrals for Specialty Services

X. **Action Item**: Vote on Proposed Rule Changes: Chairman, Steven Crawford, M.D.

XI. Informational Items (No Discussion): Demetria Bennett, Policy Development Coordinator

XII. New Business: Chairman, Steven Crawford, M.D.

XIII. Adjourn

Next Meeting
March 12, 2015
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

Welcome

Dr. Crawford opened the meeting at 1:00 with the introductions of a new alternate for the Oklahoma Chiropractic Association, David Waggoner. He also announced the resignation of Tanya Case who had been a member at large and is now a board member of the Oklahoma Health Care Authority. (OHCA)

Roll Call

Delegates present: Teresa Bierig, Debbie Booten-Hiser, Mary Brinkley, Steven Crawford, Wanda Felty, Terrie Fritz, Samantha Galloway, Melissa Gastorf, Steve Goforth, Stanley Grogg, Mark Jones, Denae Kirkpatrick, Annette Mays, Daniel Post, Anttonia Pratt-Reid, Edd Rhoades, Jason Rhynes, William Simon, Rick Snyder, Jeff Tallent, Richard Walton, Phil Woodward, and Paul Wright.

Alternates present: Shelly Collins and Traylor Rains

Delegates absent: David Cavallaro, Liz Moran, and James Patterson

Member Comments

Dr. Kirkpatrick, representing the Oklahoma Dental Association, expressed concern about the way in which dental providers' offices are being audited. She noted that non-dental professionals were involved and that large fines were assessed; $900,000 in one instance was reduced to $300 after a lengthy appeal process. She warned that contracts with dental providers could drop off if the current process continued and made four suggestions: peer-to-peer review, clear guidelines and rules, formal in-person education, and keeping the auditing function in house rather than contracting it out.

Approval of Minutes

Dr. Post moved to accept the minutes of the September 3, 2014 meeting without any corrections or changes, Dr. Grogg seconded the motion and they were accepted unanimously.

Financial Report

Gloria Hudson, OHCA Director of General Accounting presented the summary of the first quarter of 2015 financial statements included in the MAC members' online packet. There were no questions following her presentation.

SoonerCare Operations Update

Becky Pasternik-Ikard, OHCA Deputy State Medicaid Director, reported on stable SoonerCare enrollment figures. Insure Oklahoma had 17,309 enrollees with only 4,536 of them participating in the Individual Plan due to a reduction of the percentage of the Federal Poverty Level for eligibility. She noted that OHCA is launching a targeted marketing plan to increase participation. She also highlighted the growth of the number of Patient-Centered Medical Homes (PCMH), marking successful efforts by Provider Services and the Medical Home Review team.

Pharmacy Update: Quantity Limit Edit – Short-Acting Painkillers

Burl Beasley explained the new restrictions on the amount of painkillers that can be prescribed, an effort of OHCA to reduce the number of people who overdose on prescription painkillers. Oklahoma ranks in the top five of all states in the number of painkillers prescribed per citizen. Dr. Post, representing the Oklahoma Chiropractors Association, urged OHCA to approve chiropractors as reimbursable providers, suggesting that the number of painkiller prescriptions could be reduced.

Further discussion explored the issues surrounding the limit, including e-prescribing, the potential ways providers may try to work-around the limits, and the importance of effectively communicating the new limits.

Stakeholder Survey

Patrick Schlecht, OHCA Planning Coordinator, introduced Sarah Coleman from the Oklahoma University Health and Science Center and the survey they have planned to measure the efforts of the agency in meeting its seventh goal, collaboration. Ms. Coleman offered electronic versions of the survey and welcomed suggestions on its design and content before November 29.

SoonerCare Choice and Insure Oklahoma Waiver Extension: 2016-2018

Sherris Harris-Osasonya, OHCA Waiver Development Coordinator made the announcement that the agency is intending to request an extension for the waivers that allow for SoonerCare Choice, which includes the PCMH, Health Access Network, and the Health Management Program, and for Insure Oklahoma. She directed the members to the OHCA public website or to her directly to make comments.

Review of Patient-Centered Medical Homes Audits

Beverly Rupert, manager of the SoonerCare compliance audit department, reviewed the last four years of compliance audits for Medical Homes and changes in the metrics to give more weight to more important criteria. No discussion followed.

Action Items / Proposed Rule Changes

Melinda Thomason, Health Policy Assistant Director, gave an overview of the role of the Medical Advisory Committee in reviewing proposed rule changes, introduced Ray Hester and Kristi Blackburn from the Oklahoma Department of Human Services providing subject matter expertise. She then reviewed the particulars of two emergency rule change proposals.

- 14-34: cleaning up and changing Oklahoma Administrative Rule (OAR) 317.40.1 concerning the waiting list for psychological evaluations for Home and Community-Based Services eligibility. Ms. Felty asked for clarification that (b)(3), Program provisions, did indeed offer choices for the setting of services. Ms. Blackburn confirmed that. Ms. Felty also expressed concern about the broad parameters of section (c)(4), Request list, might lead to a restrictive interpretation. Ms. Blackburn and Ms. Galloway explained that the revised policy would not change the current unofficial process.

Mr. Tallent moved for the approval of the change, Ms. Galloway seconded, and the motion passed unanimously.

- 14-23: cleaning up and changing Oklahoma Administrative Rule (OAR) 317.40.5 concerning recent changes in the Fair Labor Act impact on HCBS, particularly, Agency companion services allowing for a contractual relationship. Ms. Mays clarified that the Department of Labor has postponed enforcement of the new law until June 1. Ms. Thomason acknowledged the date and noted that the change will prepare OHCA for the change when it does occur. Ms. Mays also noted that her organization, the National Association for Home Care & Hospice has filed a lawsuit to constrain the Department of Labor from changing the HCBS rules.

Mr. Tallent moved the approval of the change, Mr. Rains seconded, and the motion passed unanimously.

Informational Items

Ms. Thomason proceeded to inform the committee that nineteen proposed rule amendments were under research for possible future approval. She mentioned that the changes were posted on the agencies public website and encouraged the members to carefully review the changes to identify any that may impact their constituencies.

2015 Meeting Dates

Dr. Crawford presented the dates of January 15, 2015; March 19, 2015; May 21, 2015; July 16, 2015; September 17, 2015; and November 19, 2015 for next year's meeting dates. Discussion about Spring Break brought a motion from Ms. Fritz to change the March date to the twelfth. Dr. Wright seconded and the motion passed without objection. Ms. Fritz then moved to accept the amended schedule. Dr. Wright seconded and the vote was 20 in favor and 3 opposed.

2015 Officers

Dr. Crawford entertained nominations for the Vice-Chairman position. Mr. Goforth nominated Dr. McNeill to return to the position of Vice-Chair. Ms. Mays seconded the nomination and the vote to accept Dr. McNeill was unanimous.
Dr. Crawford opened the floor for nominations for the Chairman positon. Mr. Tallent nominated Dr. Crawford, Dr. Grogg seconded, and the nomination was approved by acclamation.

New Business

There being no new business, Dr. Crawford asked for a motion to adjourn.

Adjournment

Ms. Fritz moved for adjournment, Mr. Tallent seconded, and the members voted unanimously with their exit from the table.

- Revenues for OHCA through November, accounting for receivables, were **$1,729,736,026** or **1% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,654,177,682 or 1.8% under** budget.
- The state dollar budget variance through November is a **positive $14,101,252.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		9.5
Administration		2.4
Revenues:		
Drug Rebate		(.2)
Taxes and Fees		2.3
Overpayments/Settlements		.1
Total FY 15 Variance	**$**	**14.1**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2015, For the Five Months Ended November 30, 2014

REVENUES	FY15 Budget YTD	FY15 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 449,834,829	$ 449,834,829	$ -	0.0%
Federal Funds	991,572,063	972,632,920	(18,939,143)	(1.9)%
Tobacco Tax Collections	18,704,841	21,012,645	2,307,804	12.3%
Quality of Care Collections	32,329,408	31,927,156	(402,252)	(1.2)%
Prior Year Carryover	61,029,661	61,029,661	-	0.0%
Federal Deferral - Interest	94,309	94,309	-	0.0%
Drug Rebates	68,628,577	68,080,719	(547,858)	(0.8)%
Medical Refunds	18,844,207	19,622,052	777,845	4.1%
Supplemental Hospital Offset Payment Program	97,592,168	97,592,168	-	0.0%
Other Revenues	7,872,522	7,909,567	37,045	0.5%
TOTAL REVENUES	**$ 1,746,502,585**	**$ 1,729,736,026**	**$ (16,766,559)**	**(1.0)%**

EXPENDITURES	FY15 Budget YTD	FY15 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 23,750,978**	**$ 21,245,848**	**$ 2,505,130**	**10.5%**
ADMINISTRATION - CONTRACTS	**$ 51,427,655**	**$ 47,835,998**	**$ 3,591,657**	**7.0%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	16,255,995	15,440,140	815,856	5.0%
Acute Fee for Service Payments:				
Hospital Services	375,131,901	370,191,214	4,940,687	1.3%
Behavioral Health	8,528,899	8,243,542	285,357	3.3%
Physicians	208,013,720	202,189,946	5,823,774	2.8%
Dentists	57,733,970	56,517,701	1,216,270	2.1%
Other Practitioners	17,908,271	17,428,112	480,158	2.7%
Home Health Care	8,661,016	8,519,120	141,896	1.6%
Lab & Radiology	33,520,732	33,867,112	(346,380)	(1.0)%
Medical Supplies	16,718,967	16,429,713	289,254	1.7%
Ambulatory/Clinics	52,242,431	52,697,640	(455,209)	(0.9)%
Prescription Drugs	194,798,903	187,373,218	7,425,684	3.8%
OHCA Therapeutic Foster Care	852,235	844,047	8,189	1.0%
Other Payments:				
Nursing Facilities	242,692,852	240,591,638	2,101,214	0.9%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	25,544,345	25,225,725	318,619	1.2%
Medicare Buy-In	56,492,027	55,103,433	1,388,594	2.5%
Transportation	29,929,934	30,150,190	(220,256)	(0.7)%
Money Follows the Person-OHCA	432,679	265,877	166,801	0.0%
Electonic Health Records-Incentive Payments	7,740,070	7,740,070	-	0.0%
Part D Phase-In Contribution	31,594,639	31,293,505	301,134	1.0%
Supplemental Hospital Offset Payment Program	224,983,892	224,983,892	-	0.0%
Total OHCA Medical Programs	**1,609,777,478**	**1,585,095,836**	**24,681,642**	**1.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,685,045,493**	**$ 1,654,177,682**	**$ 30,867,811**	**1.8%**

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2015, For the Five Months Ended November 30, 2014

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 15,502,432	$ 15,433,889	$ -	$ 62,292	$ -	$ 6,251	$ -
Inpatient Acute Care	447,817,674	255,159,223	202,786	1,618,044	180,456,312	531,186	9,850,122
Outpatient Acute Care	146,131,251	112,434,976	17,335	1,699,041	30,134,190	1,845,708	
Behavioral Health - Inpatient	24,214,017	5,051,240	-	116,765	13,847,473		5,198,538
Behavioral Health - Psychiatrist	3,738,219	3,192,302	-	-	545,917	-	-
Behavioral Health - Outpatient	11,958,476	-	-	-	-	-	11,958,476
Behavioral Health Facility- Rehab	105,148,413	-	-	-	-	38,067	105,148,413
Behavioral Health - Case Management	8,579,437	-	-	-	-	-	8,579,437
Behavioral Health - PRTF	37,084,605	-	-	-	-	-	37,084,605
Residential Behavioral Management	9,486,302	-	-	-	-	-	9,486,302
Targeted Case Management	26,854,411	-	-	-	-	-	26,854,411
Therapeutic Foster Care	844,047	844,047	-	-	-	-	-
Physicians	227,337,359	199,598,809	24,209	2,444,026	-	2,566,928	22,703,388
Dentists	56,525,443	56,512,476	-	7,742	-	5,225	-
Mid Level Practitioners	1,465,525	1,456,454	-	8,316	-	754	-
Other Practitioners	16,012,923	15,782,778	185,985	42,019	-	2,141	-
Home Health Care	8,523,585	8,510,589	-	4,465	-	8,531	-
Lab & Radiology	34,621,624	33,642,242	-	754,512	-	224,870	-
Medical Supplies	16,544,085	15,253,858	1,129,806	114,372	-	46,049	-
Clinic Services	51,988,317	48,849,577	-	287,910	-	88,823	2,762,007
Ambulatory Surgery Centers	3,845,464	3,748,484	-	86,223	-	10,756	-
Personal Care Services	5,305,869	-	-	-	-	-	5,305,869
Nursing Facilities	240,591,638	151,386,908	89,202,748	-	-	1,982	-
Transportation	29,993,293	28,863,105	1,100,039	-	-	30,150	-
GME/IME/DME	37,603,503	-	-	-	-	-	37,603,503
ICF/IID Private	25,225,725	20,665,099	4,560,626	-	-	-	-
ICF/IID Public	30,266,719	-	-	-	-	-	30,266,719
CMS Payments	86,396,938	86,116,460	280,479	-	-	-	
Prescription Drugs	191,090,789	186,608,309	-	3,717,571	-	764,909	-
Miscellaneous Medical Payments	156,897	148,370	-	-	-	8,527	-
Home and Community Based Waiver	78,210,365	-	-	-	-	-	78,210,365
Homeward Bound Waiver	37,741,975	-	-	-	-	-	37,741,975
Money Follows the Person	6,301,006	265,877	-	-	-	-	6,035,129
In-Home Support Waiver	10,683,211	-	-	-	-	-	10,683,211
ADvantage Waiver	69,216,640	-	-	-	-	-	69,216,640
Family Planning/Family Planning Waiver	3,588,825	-	-	-	-	-	3,588,825
Premium Assistance*	17,327,709	-	-	17,327,709	-	-	-
Electronic Health Records Incentive Payments	7,740,070	7,740,070	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,131,664,779**	**$ 1,257,265,139**	**$ 96,704,013**	**$ 28,291,009**	**$ 224,983,892**	**$ 6,180,858**	**$ 518,277,934**

* Includes $17,194,543.34 paid out of Fund 245

Oklahoma Health Care Authority

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2015, For the Five Months Ended November 30, 2014

		FY15 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	213,112,195
Federal Funds		330,168,068
TOTAL REVENUES	**$**	**543,280,263**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	78,210,365
Money Follows the Person		6,035,129
Homeward Bound Waiver		37,741,975
In-Home Support Waivers		10,683,211
ADvantage Waiver		69,216,640
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		30,266,719
Personal Care		5,305,869
Residential Behavioral Management		7,287,712
Targeted Case Management		22,037,004
Total Department of Human Services		**266,784,624**
State Employees Physician Payment		
Physician Payments		22,703,388
Total State Employees Physician Payment		**22,703,388**
Education Payments		
Graduate Medical Education		211,228
Graduate Medical Education - Physicians Manpower Training Commission		2,172,666
Indirect Medical Education		31,865,924
Direct Medical Education		3,353,685
Total Education Payments		**37,603,503**
Office of Juvenile Affairs		
Targeted Case Management		1,083,673
Residential Behavioral Management		2,198,590
Total Office of Juvenile Affairs		**3,282,263**
Department of Mental Health		
Case Management		8,579,437
Inpatient Psychiatric Free-standing		5,198,538
Outpatient		11,958,476
Psychiatric Residential Treatment Facility		37,084,605
Rehabilitation Centers		105,148,413
Total Department of Mental Health		**167,969,470**
State Department of Health		
Children's First		654,439
Sooner Start		1,010,797
Early Intervention		1,595,393
Early and Periodic Screening, Diagnosis, and Treatment Clinic		886,282
Family Planning		(35,853)
Family Planning Waiver		3,611,584
Maternity Clinic		16,750
Total Department of Health		**7,739,391**
County Health Departments		
EPSDT Clinic		328,455
Family Planning Waiver		13,094
Total County Health Departments		**341,549**
State Department of Education		**81,651**
Public Schools		**1,402,250**
Medicare DRG Limit		**4,500,000**
Native American Tribal Agreements		**519,724**
Department of Corrections		**613,325**
JD McCarty		**4,736,798**
Total OSA Medicaid Programs	**$**	**518,277,934**
OSA Non-Medicaid Programs	**$**	**32,773,825**
Accounts Receivable from OSA	**$**	**7,771,496**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
Fiscal Year 2015, For the Five Months Ended November 30, 2014

REVENUES		FY 15 Revenue
SHOPP Assessment Fee	$	97,494,858
Federal Draws		142,145,109
Interest		61,333
Penalties		35,977
State Appropriations		(15,200,000)
TOTAL REVENUES	$	224,537,277

EXPENDITURES	Quarter	Quarter		FY 15 Expenditures
Program Costs:	7/1/14 - 9/30/14	10/1/14 - 12/31/14		
Hospital - Inpatient Care	92,872,986	87,583,326	$	180,456,311
Hospital -Outpatient Care	15,052,817	15,081,373	$	30,134,190
Psychiatric Facilities-Inpatient	6,919,304	6,928,169	$	13,847,473
Rehabilitation Facilities-Inpatient	272,784	273,133	$	545,917
Total OHCA Program Costs	115,117,891	109,866,001	$	224,983,892
Total Expenditures			$	224,983,892

CASH BALANCE		
	$	(446,615)

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2015, For the Five Months Ended November 30, 2014

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 31,911,177**	**$ 31,911,177**
Interest Earned	**15,979**	**15,979**
TOTAL REVENUES	**$ 31,927,156**	**$ 31,927,156**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 87,681,416	$ 31,547,774	
Eyeglasses and Dentures	115,411	41,532	
Personal Allowance Increase	1,405,920	505,850	
Coverage for Durable Medical Equipment and Supplies	1,129,806	406,504	
Coverage of Qualified Medicare Beneficiary	430,315	154,827	
Part D Phase-In	280,479	280,479	
ICF/IID Rate Adjustment	2,230,662	802,592	
Acute Services ICF/IID	2,329,964	838,321	
Non-emergency Transportation - Soonerride	1,100,039	395,794	
Total Program Costs	**$ 96,704,013**	**$ 34,973,673**	**$ 34,973,673**
Administration			
OHCA Administration Costs	$ 213,391	$ 106,695	
DHS-Ombudsmen	85,376	85,376	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 298,767**	**$ 192,071**	**$ 192,071**
Total Quality of Care Fee Costs	**$ 97,002,780**	**$ 35,165,744**	
TOTAL STATE SHARE OF COSTS			**$ 35,165,744**

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

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2015, For the Five Months Ended November 30, 2014

REVENUES	FY 14 Carryover	FY 15 Revenue	Total Revenue
Prior Year Balance	$ 13,950,701	$ -	$ 7,160,577
State Appropriations	-	-	-
Tobacco Tax Collections	-	17,282,743	17,282,743
Interest Income	-	130,361	130,361
Federal Draws	160,262	11,463,492	11,463,492
All Kids Act	(6,697,761)	47,335	47,335
TOTAL REVENUES	**$ 7,413,202**	**$ 28,923,931**	**$ 36,037,173**

EXPENDITURES		FY 14 Expenditures	FY 15 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 17,063,169	$ 17,063,169
	College Students		133,166	47,913
	All Kids Act		131,375	131,375
Individual Plan				
	SoonerCare Choice		$ 60,096	$ 21,623
	Inpatient Hospital		1,595,438	574,038
	Outpatient Hospital		1,678,722	604,004
	BH - Inpatient Services-DRG		113,999	41,017
	BH -Psychiatrist		-	-
	Physicians		2,437,878	877,148
	Dentists		7,123	2,563
	Mid Level Practitioner		7,847	2,823
	Other Practitioners		41,349	14,877
	Home Health		4,465	1,606
	Lab and Radiology		747,773	269,049
	Medical Supplies		105,988	38,134
	Clinic Services		285,618	102,765
	Ambulatory Surgery Center		80,493	28,961
	Prescription Drugs		3,667,193	1,319,456
	Miscellaneous Medical		-	-
	Premiums Collected		-	(212,460)
Total Individual Plan			**$ 10,833,980**	**$ 3,685,606**
	College Students-Service Costs		**$ 129,134**	**$ 46,463**
	All Kids Act- Service Costs		**$ 186**	**$ 67**
Total OHCA Program Costs			**$ 28,291,009**	**$ 20,974,592**
Administrative Costs				
	Salaries	$ 30,565	$ 523,203	$ 553,768
	Operating Costs	125,839	266,755	392,594
	Health Dept-Postponing	-	-	-
	Contract - HP	96,221	347,146	443,367
Total Administrative Costs		**$ 252,625**	**$ 1,137,103**	**$ 1,389,728**
Total Expenditures				**$ 22,364,320**
NET CASH BALANCE		**$ 7,160,577**		**$ 13,672,853**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2015, For the Five Months Ended November 30, 2014

REVENUES	FY 15 Revenue	State Share
Tobacco Tax Collections	$ 344,821	$ 344,821
TOTAL REVENUES	**$ 344,821**	**$ 344,821**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 6,251	$ 1,575	
Inpatient Hospital	531,186	133,806	
Outpatient Hospital	1,845,708	464,934	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,982	499	
Physicians	2,566,928	646,609	
Dentists	5,225	1,316	
Mid-level Practitioner	754	190	
Other Practitioners	2,141	539	
Home Health	8,531	2,149	
Lab & Radiology	224,870	56,645	
Medical Supplies	46,049	11,600	
Clinic Services	88,823	22,374	
Ambulatory Surgery Center	10,756	2,709	
Prescription Drugs	764,909	192,681	
Transportation	30,150	7,595	
Miscellaneous Medical	8,527	2,149	
Total OHCA Program Costs	$ 6,142,791	$ 1,547,370	
OSA DMHSAS Rehab	$ 38,067	$ 9,589	
Total Medicaid Program Costs	$ 6,180,858	$ 1,556,959	
TOTAL STATE SHARE OF COSTS			**$ 1,556,959**

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.

November 2014 Data for January 2015 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2014	Enrollment November 2014	Total Expenditures November 2014	Average Dollars Per Member Per Month November 2014
SoonerCare Choice Patient-Centered Medical Home		559,363	**541,261**	**$142,020,032**	
	Lower Cost (Children/Parents; Other)		494,352	$102,349,245	$207
	Higher Cost (Aged, Blind or Disabled; TEFRA; BCC)		46,909	$39,670,787	$846
SoonerCare Traditional		196,936	**237,089**	**$180,791,280**	
	Lower Cost (Children/Parents; Other)		126,130	$42,217,967	$335
	Higher Cost (Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)		110,959	$138,573,312	$1,249
SoonerPlan*		48,266	**41,979**	**$370,623**	$9
Insure Oklahoma		23,567	**17,326**	**$5,297,754**	
	Employer-Sponsored Insurance	14,795	12,764	$3,340,444	$262
	*Individual Plan**	8,772	4,562	$1,957,310	$429
TOTAL		**828,131**	**837,655**	**$328,479,689**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $21,245,415 are excluded.

Effective July 2014, members with other forms of credible health insurance coverage were no longer eligible for Choice PCMH.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

Net Enrollee Count Change from Previous Month Total	1,336

New Enrollees	13,840

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare		Monthly Average SFY2014	Enrolled November 2014
Dual Enrollees		**109,653**	**110,976**
	Child	*192*	185
	Adult	*109,461*	110,791

		Monthly Average SFY2014	Enrolled November 2014	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,358**	**15,178**	**$3,476**
	Child	63	57	
	Adult	15,295	15,121	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2014	Enrolled November 2014
Total Providers		**38,330**	**41,174**
	In-State	29,277	30,549
	Out-of-State	9,053	10,625

Provider Network includes providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and specialties.

Program	% of Capacity Used
SoonerCare Choice	43%
SoonerCare Choice I/T/U	19%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2014	*Enrolled November 2014**	Monthly Average SFY2014	Enrolled November 2014
Physician	*8,452*	*9,041*	*13,597*	15,293
Pharmacy	*936*	*892*	*1,266*	1,172
Mental Health Provider	*4,864*	*4,516*	*4,902*	4,570
Dentist	*1,069*	*1,100*	*1,206*	1,257
Hospital	*183*	*191*	*685*	916
Optometrist	*565*	*609*	*594*	644
Extended Care Facility	*356*	*349*	356	349

Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers**	*5,410*	*5,899*	7,011	7,848
Patient-Centered Medical Home	*2,099*	*2,323*	2,188	2,431

**Including Physicians, Physician Assistants and Advance Nurse Practitioners.

*Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

Budget Request Detail

OKLAHOMA HEALTH CARE AUTHORITY
SFY 2016
Budget Request Detail

Description of Priority	# FTE	State	Total
1 **Annualizations**			
FFP Match Rate from 62.30% to 60.99%		45,495,897	-
Medicare A & B Premiums - 01/01/15		(721,616)	(1,865,485)
Additonal State Dollars to cover CHIP population under Title 19		14,441,839	-
	-	**59,216,120**	**(1,865,485)**
2 **Maintenance**			
FY'16 Growth/Utilization Increases (4%)		45,006,252	124,335,841
Medicare A & B premiums - 01/01/2016		(455,670)	(1,168,084)
Medicare Part D (clawback) - 100% State		2,539,377	2,539,377
Rebase physician fee schedule to align with current RVUs		2,135,637	5,520,938
	-	**49,225,596**	**131,228,072**
3 **One-Time Funding**			
FY-14 Onetime Carryover & Replace		31,029,661	-
	-	**31,029,661**	**-**
4 **Mandates**			
Administrative Law Judge & Paralegal	2.0	30,064	60,128
	2.0	**30,064**	**60,128**
5 **Provider Rate Maintenance**			
Inpatient Hosp DRG / Per diem		21,815,081	56,395,219
Outpatient Hosp		9,942,100	25,701,804
SoonerCare Choice Care Management		343,944	889,146
Behavioral Health (OHCA)		950,442	2,457,034
Nursing Facilities (100% of Allowable Costs)		23,903,575	61,794,287
ICF/MR's (100% of Allowable Costs)		752,894	1,946,344
Physicians (Increase to 100% of Medicare)		18,926,812	48,928,617
Dental		5,921,718	15,308,519
Mid-Level Practioners		148,305	383,392
Other Practitioner		1,598,566	4,132,529
Home Health		243,493	629,466
Lab & Radiology		2,695,401	6,968,011
Clinic Services		635,325	1,642,408
Ambulatory Surgery Center (ASC)		372,586	963,190
Durable Medical Equipment (DME)		1,488,605	3,848,264
Pharmacy Dispensing Fees		1,243,399	3,214,371
Crossovers		11,501,002	29,731,797
	-	**102,483,248**	**264,934,397**
FY-2016 Budget Request Priorities	**2.0**	**$ 241,984,689**	**$ 394,357,113**

Note: If CHIP is reauthorized thru FFY 2019 , Priority #1 will decrease by $42 million
FFY 16 Enhanced CHIP rate is 72.69%, will increase to 95.69% if reauthorized

HB 2906- ER Utilization Study Abstract

The topic of non-emergent ER utilization has been, and continues to be, of interest to state elected officials especially as budget constraints are requiring additional pressure to reduce cost points. Passed during the 2014 session, House Bill 2906, authored by Representative David Derby and Senator Rob Standridge, directs the Oklahoma Health Care Authority to study and prepare a report dealing with non-emergent emergency room utilization among SoonerCare members.

As part of that directive the OHCA initially completed an internal exploration of the methods and approaches utilized by the OHCA to obtain an assessment of the current OHCA environment in regards to non-emergent ER utilization rates by SoonerCare members. In addition to the completion of the internal exploration of methods and approaches utilized by the OHCA, an external examination of OHCA stakeholder input was completed. As part of this external examination an internal steering committee was formed to provide a forum for sharing known non-emergent ER utilization topics, act as a sounding board, shape recommendations and to identify stakeholders that could provide beneficial input on non-emergent ER utilization topics.

Major challenges that were identified from meetings with external groups dealt with access to care, behavioral health, organizational issues and regulatory issues. Recommendations were given by these groups and the internal working group that fell into four major categories: technology; alternative payment models; member and provider education; and staffing. As shown through independent, external evaluations, Oklahoma’s patient-centered medical home (PCMH) and care coordination models have a demonstrated positive impact on non-emergent ER use by SoonerCare members. In addition to evaluating and implementing recommendations included in this report, the OHCA will continue to invest resources into the PCMH and Health Access Network models. Specifically, the OHCA anticipates exploring the inclusion of additional SoonerCare population groups beyond the current SoonerCare Choice population and searching for opportunities to enhance health information sharing among providers.

Face to face tribal consultations regarding the following proposed changes were held Tuesday, November 4, 2014 and Tuesday, January 6, 2015 in the Board Room of the OHCA.

The following rules were posted for comment on December 16, 2014 through January 15, 2015.

14-09 SoonerCare Choice Policy Change-These rule changes have already been reviewed during the emergency rule process with the exception of the following proposed change: rules are revised to exclude children in the former foster care eligibility group from participation in SoonerCare Choice to align with waiver authority. Rules are also revised to allow children who are known to be in OKDHS custody the option to participate in the SoonerCare Choice program.
Budget Impact: This rule change has total projected budget savings of $3,887,634; total state savings are projected as $1,448,921

14-18 Policy Change for State Plan Personal Care Services-Proposed policy for the State Plan Personal Care services are amended to align with current procedures that are in place at OKDHS. Changes include: policy clean up to remove unnecessary language regarding personal care service settings and criteria for persons eligible to serve as Personal Care Assistants. Rules also clarify the service eligibility criteria to match the terms and standards of the Uniform Comprehensive Assessment Tool (UCAT), and minor changes to language regarding the administration of State Plan Personal Care services to match current processes and protocol currently in place at OKDHS.
Budget Impact: Budget neutral

14-24 340B Drug Discount Program-The proposed 340B Drug Discount program rule is being added to comply with a federal mandate. The purpose of this rule is to outline special provisions for providers participating in the 340B Drug Discount program. The changes to this program will increase transparency in drug pricing. Changes to the program include aligning reimbursement rates for all drugs closer to the actual price the pharmacy pays for the drug; increasing rebates paid by drug manufacturers; providing rebates for drugs dispensed to SoonerCare members; and lowering reimbursement for certain generic drugs. This change was inadvertently left out when the 340B changes were made in 2013.
Budget Impact: Budget neutral

14-26 Certified Nursing Aide (CNA) Training- Proposed Nurse Aide training rules are revised to specify payment for training will be directly reimbursed to qualified nurse aides on a quarterly basis for every quarter the individual is employed in a nursing facility. Reimbursement outside of the first 12 months is not compensable. Additionally, rules establish a maximum rate for reimbursement for nurse aides who have paid for training and competency examination fees.
Budget Impact: This rule change has total projected budget savings of $1,509,000; total state savings are projected as $529,500

14-27 Private Duty Nursing services- Proposed Private Duty Nursing (PDN) rules are revised to reflect an OHCA physician will be responsible for utilizing the acuity grid to make a determination for medical necessity, including approving the number of hours for service. The Care Management nurses' responsibility will be to gather, summarize, and present the individual cases to the physician.
Budget Impact: Budget Neutral

14-29A&B Lock-in Policy Clean Up-Proposed pharmacy lock-in policy is amended for clarification purposes to lock members in to a single pharmacy and prescriber rather than a single physician and pharmacy. As a result the member is not restricted to one physician; however, the member will be locked in to one pharmacy and must receive prescriptions from an identified and approved lock-in prescriber. Rules are also revised for cleanup purposes to remove references to the terms Medicaid and recipient as these terms are outdated, rules now reflect SoonerCare and member.
Budget Impact: Budget neutral

14-35 DMEPOS Free Choice-Proposed policy for SoonerCare members' freedom of choice to select their provider of durable medical equipment, prosthetics, and orthotics supplies (DMEPOS) are amended to state that providers must inform members of this right when filling or ordering DMEPOS.
Budget Impact: Budget neutral

14-41 Referrals for Specialty Services-Proposed policy is amended to remove language regarding the inclusion of written referral documentation in members' medical records. The referral will still be captured and maintained in the member record; however, the use of electronic referrals will replace the need of paper documentation.
Budget Impact: Budget neutral

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 7. SOONERCARE
PART 3. ENROLLMENT CRITERIA

317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members are enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a nursing facility, in an ~~intermediate care facility for the mentally retarded (ICF-MR)~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver.

(2) Individuals privately enrolled in an HMO.

(3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services.

(4) ~~Children who are known to the OHCA to be in custody, as reported by the Oklahoma Department of Human Services.~~ Individuals in the former foster care children's group (see OAC 317:35-5-2).

(5) Individuals who are eligible for SoonerCare solely due to presumptive eligibility.

(6) Non-qualified or ineligible aliens.

(7) Children in subsidized adoptions.

(8) Individuals who are dually-eligible for SoonerCare and Medicare.

(9) Individuals who are in an Institution for Mental Disease (IMD).

(10) Individuals who have other primary medical insurance.

PART 5. ENROLLMENT PROCESS

317:25-7-28. Disenrolling a member from SoonerCare

(a) The OHCA may disenroll a member from SoonerCare if:

(1) the member is no longer eligible for SoonerCare services;

(2) the member has been incarcerated;

(3) the member dies;

(4) disenrollment is determined to be necessary by the OHCA;

(5) the status of the member changes, rendering him/her ineligible for SoonerCare;

~~(6) the member is already enrolled in the SoonerCare Program, when they are taken or found to be in custody as reported by the Oklahoma Department of Human Services;~~

~~(7)~~(6) the member is authorized to receive services in a nursing facility, in an ~~intermediate care facility for the~~

~~mentally retarded (ICF-MR)~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver; ~~or~~

~~(8)~~ (7) the member becomes dually-eligible for SoonerCare and Medicare~~.~~; or

(8) the member becomes covered under other primary medical insurance.

(b) The OHCA may disenroll the member at any time if the member is disenrolled for good cause, as it is defined in OAC 317:25-7-27. The OHCA will inform the PCP of any disenrollments from his or her member roster.

(c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.

(1) The PCP may file a written request asking OHCA to take action including, but not limited to, disenrolling a member when the member:

(A) is physically or verbally abusive to office staff, providers and/or other patients;

(B) is habitually non-compliant with the documented medical directions of the PCP; or

(C) regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.

(2) The request from the PCP for disenrollment of a member must include one of more of the following:

(A) documentation of the difficulty encountered with the member including the nature, extent, and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;

(B) identification and documentation of unique religious or cultural issues that may be effecting the PCP's ability to provide treatment effectively to the member; or

(C) documentation of special assistance or intervention offered.

(3) The PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with the PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) The PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior, including disenrollment from the PCP.

(5) The OHCA will give written notice of the disenrollment request to the member.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to QMBP, SLMB, and other SoonerCare service eligibility

Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities (refer to OAC 317:35-9), persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9), Home and Community Based Waiver Services for the Intellectually Disabled (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ADvantage program (refer to OAC 317:35-17), and Personal Care services (refer to this subchapter). Personal Care provides services in the member's own home. Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind, or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary ~~(QMB)~~Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for ~~QMB~~QMBP or SLMB benefits is not required.

317:35-15-2. Personal Care services

(a) Personal Care is assistance to an individual in carrying out activities of daily living~~, such as bathing, grooming and toileting,~~ or in carrying out instrumental activities of daily living~~, such as preparing meals and doing laundry or errands~~ directly related to the member's personal care needs~~, to assure personal health and safety of the individual or~~ to prevent or minimize physical health regression or deterioration. The Personal Care service requires a skilled nursing assessment of need, development of a care plan to meet identified personal care needs, care plan oversight and periodic re-assessment and updating, if necessary, of the care plan. Personal Care services do not include technical services such as~~,~~ tracheal suctioning, bladder catheterization, colostomy irrigation, ~~and~~or the operation of equipment of a technical nature such as a patient lift.

(b) ~~Personal Care services support informal care being provided~~

~~in the member's home. A rented apartment, room or shelter shared with others is considered "the member's home". A facility which meets the definition of a nursing facility, room and board, licensed residential care facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-899.1 et seq., and Section 1-1902 et seq., and/or in any other typed of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not considered the "the member's home" for delivery of SoonerCare Personal Care Program services.~~Personal Care members may receive services in limited types of living arrangements. The specific living arrangements are set forth below.

(1) Personal Care members are not eligible to receive services while residing in an institutional setting including, but not limited to, licensed facilities, such as a hospital, nursing facility, licensed residential care facility or licensed assisted living facility, or in an unlicensed institutional living arrangement, such as a room and board home or facility.

(2) Additional living arrangements in which members may receive Personal Care services are the member's own home, apartment, or a family or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

(3) For Personal Care members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive Personal Care services for the period during which the member is a student.

(4) With prior approval of the OKDHS area nurse, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified in the care plan.

(c) Personal Care services may be provided by an individual employed by the member referred to as ~~a~~an Individual Personal Care Assistant ~~(PCA)~~(IPCA) or by a ~~qualified employee of a~~Personal Care Assistant (PCA) employed by a home care agency that is certified to provide Personal Care services and contracted with the OHCA to provide Personal Care services. OKDHS must determine ~~a PCA~~an IPCA to be qualified to provide Personal Care services before they can provide services. Persons eligible to serve as either IPCAs or PCAS must meet the following criteria:

(1) are at least 18 years of age;

(2) have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;
(3) are not included in the OKDHS Community Services Worker Registry;
(4) have not been convicted of a crime or have any criminal background history or registry listings that prohibit employment as defined in O.S. Title 63, Section 1-1950.1;
(5) demonstrate the ability to understand and carry out assigned tasks;
(6) are not a legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served (exceptions may be made for a legal guardian to provide services only with prior approval from the OKDHS Aging Services Division);
(7) have a verifiable work history and/or personal references, verifiable identification; and
(8) meet any additional requirements as outlined in the contract and certification requirements with the OHCA.

(d) Eligibility for Personal Care is contingent on an individual requiring one or more of the services offered at least monthly that include personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet Activities of Daily Living or Instrumental Activities of Daily Living assessed needs.

317:35-15-3. Application for Personal Care

(a) **Requests for Personal Care.** A request for Personal Care is made to the local OKDHS office or ADvantage Administration (AA). A written financial application is not required for an individual who has an active SoonerCare case. A financial application for Personal Care ~~consists of the Medical Assistance Application form~~is initiated when there is no active SoonerCare case. The ~~form~~application is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf. All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes eligibility, the information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(b) **Date of application.**

(1) The date of application is:

(A) the date the applicant or someone acting on his/her

behalf signs the application in the county office;

(B) the date the application is stamped into the county office when the application is initiated outside the county office; or~~,~~

(C) the date when the request for SoonerCare is made orally and the financial application form is signed later.

(2) An exception to paragraph (1) of this subsection would occur when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contract provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for SoonerCare eligibility determination. The application date is the date the applicant signed the application form for the provider.

(c) **Eligibility status.** Financial and medical eligibility must be established before services can be initiated.

317:35-15-4. Determination of medical eligibility for Personal Care

(a) **Eligibility.** The OKDHS area nurse~~, or designee, utilizes the UCAT criteria and professional judgment in determining medical eligibility and level of care. To be eligible for Personal Care services, the individual must:~~determines medical eligibility for Personal Care services based on the UCAT and the determination that the member has unmet care needs that require Personal Care services. Personal Care services are initiated to support the informal care that is being provided in the member's home. Personal Care services are not intended to take the place of regular care and general maintenance tasks or meal preparation typically shared or done for one another, by spouses, or other adults who live in the same household. Additionally, Personal Care services are not furnished when they principally benefit the family unit. To be eligible for Personal Care services, the individual must:

(1) have adequate informal supports that contribute to care, or decision making ability as documented on the UCAT, to remain in his/her home without risk to his/her health, safety, and well-being:

(A) the individual must have the decision making ability to respond appropriately to situations that jeopardize his/her health and safety or available supports that compensate for his/her lack of ability as documented on the UCAT, or

(B) the individual who has his/her decision making ability, but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and has been

informed by the OKDHS nurse of potential risks and consequences may be eligible;

(2) require a plan of care involving the planning and administration of services delivered under the supervision of professional personnel;

(3) have a physical impairment or combination of physical and mental impairments as documented on the UCAT. An individual who poses a threat to self or others as supported by professional documentation may not be approved for Personal Care services;

(4) not have members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors;

(5) lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(b) **Definitions.** The following words and terms, when used in this subsection, have the following meaning, unless the context clearly indicates otherwise:

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

(A) bathing,

(B) eating,

(C) dressing,

(D) grooming,

(E) transferring (includes activities such as getting in and out of a tub, bed to chair, etc.),

(F) mobility,

(G) toileting, and

(H) bowel/bladder control.

(2) **"ADLs score of three or greater"** means the member cannot do at least one ADL at all or needs some help with two or more ADLs.

~~(3) **"ADLs score is two"** means the member needs some help with one ADL.~~

~~(4)~~(3) **"~~Client~~Consumer support very low need"** means the member's UCAT ~~Client~~Consumer Support score is zero which indicates, in the UCAT assessor's clinical judgment, formal and informal sources are sufficient for present level of member need in most functional areas.

~~(5)~~(4) **"~~Client~~Consumer support low need"** means the member's UCAT ~~Client~~Consumer Support score is ~~5~~five which indicates, in the UCAT assessor's clinical judgment, support from formal and informal sources are nearly sufficient for present level of member need in most functional areas. The member, family, or informal supports are meeting most needs typically expected of family or household members to share or do for one another, such as general household maintenance. There is little risk of institutional placement with loss of current supports.

~~(6)~~(5) **"~~Client~~Consumer support moderate need"** means the UCAT ~~Client~~Consumer score is 15~~,~~ which indicates, in the UCAT assessor's clinical judgment, formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The member requires additional assistance that usually includes personal care assistance with one or more ADL tasks not available through Medicare, the Veterans Administration, or other federal entitlement programs. Support provided by informal caregivers is of questionable reliability due to one or more of the following:

(A) care or support is required continuously with no relief or backup available;

(B) informal support lacks continuity due to conflicting responsibilities such as work or child care;

(C) care or support is provided by persons with advanced age or disability; or

(D) institutional placement can reasonably be expected with any loss of existing support

~~(7)~~(6) **"~~Client~~Consumer support high need"** means the member's UCAT ~~Client~~Consumer score is 25 which indicates, in the UCAT assessor's clinical judgment, formal and informal supports are not sufficient as there is very little or no support available to meet a high degree of member need.

~~(8)~~(7) **"Community Services Worker"** means any person employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities, and who is not a licensed health professional.

~~(9)~~(8) **"Community Services Worker Registry"** means a registry established by the ~~Oklahoma Department of Human Services~~OKDHS, as required by Section 1025.1 et seq. of Title 56 of the Oklahoma Statutes, to list community services workers against whom a final investigative finding of abuse, neglect, or exploitation, as defined in Section 10-103

of Title 43A of the Oklahoma Statutes, involving a frail elderly, disabled person(s), or person(s) with developmental disabilities has been made by OKDHS or an administrative law judge, amended in 2002, to include the listing of SoonerCare ~~personal care assistants~~PCAs providing personal care services.

~~(10)~~(9) **"~~Instrumental activities of daily living~~IADL"** means ~~those activities~~the instrumental activities of daily living that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

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

~~(11) **"IADL"** means the instrumental activities of daily living.~~

~~(12)~~(10) **"IADLs score is at least six"** means the member needs some help with at least three IADLs or cannot do two IADLs at all.

~~(13)~~(11) **"IADLs score of eight or greater"** means the member needs some help with at least four IADLs or the member cannot do two IADLs at all and needs some help with one or more other IADLs.

~~(14) **"SoonerCare personal care services provider"** means a program, corporation, or individual who provides services under the state's SoonerCare personal care program or ADvantage Waiver to individuals who are elderly or who have a physical disability.~~

~~(15)~~(12) **"MSQ"** means the mental status questionnaire.

~~(16)~~(13) **"MSQ moderate risk range"** means a total weighted score of seven ~~or more~~to eleven which indicates an orientation-memory-concentration impairment or ~~a~~ memory impairment.

~~(17)~~(14) **"Nutrition moderate risk"** means the total weighted UCAT Nutrition score is ~~8~~eight or more which indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

~~(18)~~(15) **"Social resources score is eight or more"** means the member lives alone or has no informal support when sick or needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for Personal Care.** The medical eligibility minimum criteria for Personal Care ~~is~~are the

minimum UCAT score criteria which a member must meet for medical eligibility for personal care and are:

(1) ~~functional~~ ADLs score is a five or greater; or IADLs score of eight or greater; or Nutrition score is eight or greater; or the MSQ score is seven or greater; or the ADLs score is three and IADLs score is at least six~~,~~; and

(2) ~~Client~~Consumer Support is ~~moderate risk~~15 or more; or ~~Client~~Consumer Support score is five and the Social Resources score is eight or more.

(d) **Medical eligibility determination.** Medical eligibility for Personal Care is determined by the ~~Oklahoma Department of Human Services~~OKDHS. The medical decision for Personal Care is made by the OKDHS area nurse~~, or designee,~~ utilizing the ~~Uniform Comprehensive Assessment Tool (UCAT)~~UCAT.

~~(1) When Personal Care services are requested, the local office is responsible for completing the UCAT, Part III.~~

~~(2)~~(1) Categorical relationship must be established for determination of eligibility for Personal Care. If categorical relationship to Aid to the Disabled has not already been established, but there is an extremely emergent need for Personal Care and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues the Authorization for Examination, OKDHS form 08MA016E, and the Report of Physician's Examination, OKDHS form 08MA02E, to a licensed medical or osteopathic physician (refer to OAC 317:30-5-1). The physician cannot be in a medical facility intern, residency, or fellowship program or in the full time employment of the Veterans Administration, Public Health Service, or other agency. The OKDHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship using the same definition used by SSA. A follow-up is required by the OKDHS county worker with the Social Security Administration (SSA) to be sure that SSA's disability decision agrees with the decision of LOCEU.

~~(3)~~(2) Approved contract agencies or the AA may complete the UCAT Part I for intake and screening and forward the form to the county office.

~~(4) When the OKDHS county office does not receive a UCAT from the AA, a UCAT I is initiated by the DHS county staff upon receipt of the referral.~~(3) Upon receipt of the referral, OKDHS county staff may initiate the UCAT, Part I.

~~(5) The OKDHS nurse completes the assessment visit within 10 working days of receipt of the referral for Personal Care from the OKDHS county worker or receipt of the UCAT I (Intake and Screening) request for Personal Care for the member who is SoonerCare eligible at the time of the request. The OKDHS nurse completes the assessment visit within 20 working days of SoonerCare application for the applicant who has not been determined financially SoonerCare eligible at the time of the request. The OKDHS county worker is responsible for contacting the applicant within three working days from the date of the receipt of the request for services to initiate the financial eligibility process.~~(4) The OKDHS nurse is responsible for completing the UCAT assessment visit within 10 working days of the Personal Care referral for the applicant who is SoonerCare eligible at the time of the request. The OKDHS nurse completes the assessment visit within 20 working days of the referral for the applicant not determined SoonerCare eligible at the time of the request. If the UCAT Part I indicates the request is from an individual who resides at home and an immediate response is required to ensure the health and safety of the person (emergency situation) or to avoid institutional placement, the UCAT Part III assessment visit has top priority for scheduling.

~~(6)~~(5) During the assessment visit, the OKDHS nurse completes the UCAT ~~III~~ and reviews with the member rights to privacy, fair hearing, ~~and~~ provider choice, and the pre-service acknowledgement agreement. The OKDHS nurse informs the ~~member~~applicant of medical eligibility criteria and provides information about ~~the different~~ OKDHS long-term care service options. The OKDHS nurse documents on the UCAT III whether the member wants to be considered for nursing facility level of care services or if the member is applying for a specific service program. If, based upon the information obtained during the assessment, the OKDHS nurse determines the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services (APS). The referral is documented on the UCAT.

(A) If the ~~member's~~applicant's needs cannot be met by Personal Care services alone, the OKDHS nurse informs the ~~member~~applicant of the other community ~~long term~~long-term care service options. The OKDHS nurse assists the ~~member~~applicant in accessing service options selected by the ~~member~~applicant in addition to, or in place of, Personal Care services.

(B) If multiple household members are applying for

SoonerCare Personal Care services, the UCAT assessment is done for all the household members at the same time.

(C) The OKDHS nurse informs the ~~member~~applicant of the qualified agencies in their local area available to provide services and obtains the ~~member's~~applicant's primary and secondary choice of agencies. If the ~~member~~applicant or family declines to choose a primary personal care service agency, the OKDHS nurse selects an agency from a list of all available agencies, using a round-robin system. The OKDHS nurse documents the name of the selected personal care ~~service~~provider agency.

~~(7)~~(6) The OKDHS nurse completes the UCAT ~~III~~ within three working days of the assessment visit and sends it to the OKDHS area nurse~~, or designee,~~ for medical eligibility determination. Personal ~~care~~Care service eligibility is established as ~~of~~ the date ~~that both~~when medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) If the length of time from the date the initial assessment to the date of service eligibility determination exceeds ~~60~~90 days, ~~the assessment must be updated as necessary including a new signature and date. A~~a new UCAT and assessment visit is required ~~if the length of time exceeds 90 days.~~

(B) ~~Upon establishment of Personal Care service eligibility, the OKDHS nurse contacts the member's preferred personal care service agency, or if necessary, the secondary agency or the agency selected by the rotation system.~~The OKDHS area nurse assigns a medical certification period of not more than 36 months. The service plan period under the Service Authorization Model (SAM) is for a period of 12 months and is provided by the OKDHS nurse.

~~(C) Within one working day of agency acceptance, the OKDHS nurse forwards the referral to the personal care service agency for Service Authorization Model (SAM) packet development. [Refer to OAC 317:35-15-8(a)]. The date the referral is forwarded is the certification effective date.~~

~~(8) Following the development of the Service Authorization Model (SAM) packet by the personal care service agency, and within three working days of receipt of the packet from the agency, the OKDHS nurse reviews the packet to ensure agreement with the plan. Once agreement is established, the packet is forwarded to the OKDHS area nurse or designees for review.~~(7)

The OKDHS area nurse notifies the OKDHS county worker via ELDERS of the Personal Care certification. The authorization line is open via automation from ELDERS and five visits by a skilled nurse are automatically authorized.

~~(9) Within 10 working days of receiving the Service Authorization Model (SAM) packet from the OKDHS nurse, the OKDHS area nurse, or designee, certifies or denies the Service Authorization Model (SAM) packet. If there is certification, the OKDHS area nurse enters into the system the units authorized. Service Authorization Model (SAM) packets that fail to meet authorization are returned to the OKDHS nurse for revision or further justification by the personal care service agency.~~(8) Upon establishment of Personal Care certification, the OKDHS nurse contacts the member's preferred provider agency, or when necessary, the secondary provider agency, or the provider agency selected by the round robin system. Within one working day of provider agency acceptance, the OKDHS nurse forwards the referral information to the provider agency for SAM plan development (see OAC 317:35-15-8(a)).

~~(10) The OKDHS area nurse, or designee, assigns a medical certification period of not more than 36 months. The service plan certification period under the Service Authorization Model (SAM) is for a period of 12 month.~~(9) Following the SAM packet development by the provider agency, and within three working days of receipt of the packet from the agency, the OKDHS nurse reviews the documentation to ensure agreement with the plan. Once agreement is established, the packet is authorized by the designee or submitted to the area nurse for review.

~~(11) Once the OKDHS nurse is notified of the service plan authorization, and within one working day, forwards copies of the certified Personal Care Service Plan [OKDHS form 02AG031E (AG-6)] to the agency.~~(10) Within 10 working days of receipt of the SAM case from the OKDHS nurse, the OKDHS area nurse either authorizes or denies the SAM units. If the SAM case fails to meet standards for authorization, the case is returned to the OKDHS nurse for revision for further justification.

~~(12) The OKDHS nurse notifies the OKDHS county worker in writing of the service and the number of authorized personal care service units including the start and end dates. The OKDHS county worker opens the service authorization. These steps are automated via ELDERS. Once the authorization is opened, five Service Authorization Model (SAM) visits by a~~

~~skilled nurse are automatically authorized.~~(11) Within one working day of knowledge of the authorization, the OKDHS nurse forwards the service plan authorization to the provider agency.

317:35-15-7. Certification for Personal Care

(a) **Personal Care certification period.** The first month of the Personal Care certification period must be the first month the member was determined eligible for Personal Care, both financially and medically.

(1) As soon as eligibility or ineligibility for Personal Care is established, the local office updates the computer form and the appropriate notice is computer generated. Notice information is retained on the notice file for county use.

(2) An applicant approved for Personal Care under SoonerCare as categorically needy is mailed a Medical Identification Card.

(b) **Financial certification period for Personal Care Services.** The financial certification period for Personal Care services is 12 months. Redetermination of eligibility is completed according to the categorical relationship.

~~(b)~~(c) **Medical certification period for Personal Care services.** A medical certification period of not more than 36 months is assigned for an individual who is approved for Personal Care. The certification period for Personal Care is based on the UCAT evaluation and clinical judgment of the OKDHS area nurse or designee.

317:35-15-8. Agency Personal Care Service Authorization and Monitoring

(a) Within ten working days of receipt of the referral for Personal Care services, the Personal Care ~~Assessment/Service Planning Nurse~~provider agency nurse completes a ~~Service Authorization Model (SAM)~~SAM visit in the home to assess the member's Personal Care service needs, completes a ~~Service Authorization Model (SAM)~~SAM packet based on the member's needs and submits the packet to the OKDHS nurse. The member's ~~Service Authorization Model (SAM)~~SAM packet includes:

(1) ~~State Plan~~ Personal Care Progress Notes (OKDHS form 02AG044E);

(2) Personal Care Planning Schedule/Service Plan [OKDHS form 02AG030E (AG-5)/02AG031E (AG-6)]; and

(3) Personal Care Plan [OKDHS form 02AG029E (AG-4)]~~; and~~.

~~(4) Personal Care Service Plan [02AG031E (AG-6)].~~

(b) If more than one person in the household has been referred to receive Personal Care services, all household members' ~~Service Authorization Model (SAM)~~SAM packets are discussed and developed with the eligible members so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of Personal Care service authorized for each individual is distributed between all eligible family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home. If one or more persons in the same household with a Personal Care member have been referred or are receiving other formal services, then those services are coordinated as well.

(c) The Personal Care ~~service~~provider agency receives ~~a certified Service Plan [OKDHS form 02AG031E (AG-6)]~~documentation from OKDHS as authorization to begin services. The agency delivers a copy of the care plan [OKDHS form 02AG029E(AG-4)] and ~~service plan~~the Personal Care Planning Schedule/Service Plan to the member upon initiating services.

(d) Prior to placing a ~~Personal Care attendant~~PCA in the member's home or other service-delivery setting, an ~~OSBI~~Oklahoma State Bureau of Investigation (OSBI) background check, ~~and~~an Oklahoma State Department of Health Registry check, and an OKDHS Community Services Worker Registry must be completed in accordance with Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide Personal Care services who also meet the criteria as defined in OAC 317:35-15-2(c)(1)(1 through 8).

(e) The ~~Personal Care Assessment/Service Planning Nurse~~provider agency nurse monitors their member's plan of care.

(1) The Personal Care ~~service~~ provider agency contacts the member within five working days of receipt of the ~~approved care Service Plan [OKDHS form 02AG031E (AG-6)]~~authorized document in order to ~~make sure~~ensure that services have been implemented and the needs of the member are being met.

(2) The ~~Personal Care Assessment/Service Planning Nurse~~provider agency nurse makes a ~~Service Authorization Model (SAM)~~SAM home visit at least every six months to assess the member's satisfaction with their care and to evaluate the ~~Service Authorization Model (SAM)~~SAM packet for adequacy of goals and ~~units~~ authorized units. Whenever a home visit is made, the ~~Personal Care Assessment/Service Planning Nurse~~the provider agency nurse documents their findings in the ~~State Plan~~ Personal Care Progress Notes ~~(OKDHS form 02AG044E)~~. The ~~personal care~~provider agency forwards a copy of the Progress Notes to the OKDHS nurse for review within 48 hours of the

visit. The monitoring visit may be conducted by ~~an LPN. If an LPN or social worker conducts the monitoring visit, an RN must~~a Licensed Practical Nurse only when the PCA is not performing hands-on personal care. A Registered Nurse must also co-sign the progress notes.

(3) Requests by the ~~Personal Care service~~provider agency nurse to change the number of units authorized in the ~~Service Authorization Model (SAM)~~SAM packet are submitted to OKDHS and are approved or denied by the OKDHS area nurse, or designee, prior to implementation of the changed number of units.

(4) Annually, or more frequently if the member's needs change, the ~~Personal Care Assessment/Service Planning Nurse~~provider agency nurse re-assesses the member's need and develops a new ~~Service Authorization Model (SAM) eligibility~~ SAM packet to meet ~~personal care~~the member's needs. The provider agency nurse conducts a home visit and completes and submits the annual reassessment documents to the OKDHS nurse no sooner than 60 days before the existing service plan end-date, but sufficiently in advance of the end-date.

(5) If the member is unstaffed, the ~~Personal Care service~~ provider agency communicates with the member and makes efforts to ~~restaff~~re-staff. The provider agency contacts unstaffed members weekly by telephone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff. If the member is unstaffed for 30 calendar days, the provider agency notifies the OKDHS nurse on an OKDHS form 02AG032E ~~(AG-7)~~, Provider Communication Form. The OKDHS nurse contacts the member and if the member chooses, initiates a transfer of the member to another ~~Personal Care service~~provider agency that can provide staff.

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

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

(1) **Payment for Personal Care.** Payment for Personal Care services is ~~generally~~ made for care provided in the member's "own home" or in other limited types of living arrangements in accordance with OAC 317:35-15-2(b)(1 through 4). ~~In addition to an owned or rented home, a rented apartment, room or~~

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

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

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

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

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

(2) **Issue resolution.**

(A) The provider agency provides a written copy of their grievance process to each member at the commencement of services. The written grievance process includes the name and phone number of a provider agency contact person who is responsible for responding to such complaints and grievances. If the member is dissatisfied with the Personal Care ~~services~~ provider agency or the assigned PCA~~,~~ and has exhausted attempts to work with the Personal Care ~~services~~provider agency's grievance process without resolution, the member may contact the OKDHS nurse to attempt to resolve the ~~issues~~issue(s). The OKDHS nurse is to contact the State Plan Care unit for issues that cannot be resolved between the OKDHS nurse and the Personal Care Provider agency. The member has the right to appeal to the OHCA in accordance with OAC 317:2-1-2. ~~For members receiving ADvantage services, the member or family should contact their case manager for the problem resolution. If the problem remains unresolved, the member or family should contact the Consumer Inquiry System (CIS). Providers are required to provide the CIS contact number to every member. The ADvantage Program member also has the right to appeal to the OHCA in accordance with OAC 317:2.~~

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

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

317:35-15-9. Redetermination of financial eligibility for Personal Care

The OKDHS county ~~worker~~Social Services Specialist must complete a redetermination of financial eligibility before the end of the certification period. A notice is generated only if there is a change which affects the ~~client's~~member's financial eligibility.

317:35-15-10. Redetermination of medical eligibility for Personal Care services

(a) **Medical eligibility redetermination.** The OKDHS area nurse~~, or designee,~~ must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.

(b) **Recertification.** The OKDHS nurse re-assesses the Personal Care services member for medical re-certification based on the member's needs and level of caregiver support required, using the UCAT at least every 36 months. During this re-certification assessment, the OKDHS nurse informs the member of the state's other SoonerCare long-term care options. The OKDHS nurse submits the re-assessment to the OKDHS area nurse~~, or designee,~~ for re-certification. Documentation is sent to the OKDHS area nurse~~, or designee,~~ no later than the tenth day of the month in which the certification expires. When the OKDHS area nurse~~, or designee~~ determines medical eligibility for Personal Care services, a re-certification review date is entered on the system.

(c) **Change in amount of units or tasks~~ within Personal Care service for Personal Care service members~~.** When the Personal Care ~~services~~provider agency determines a need for a change in the amount of units or tasks within the Personal Care service, a new ~~Personal Care Service Authorization Model (SAM)~~SAM packet is completed and submitted to OKDHS within five calendar days of identifying the assessed need. The change is approved or denied by the OKDHS area nurse, or designee, prior to implementation.

(d) **Voluntary closure of Personal Care services.** If a member decides Personal Care services are no longer needed to meet his/her needs, a medical decision is not needed. The member and the OKDHS nurse or OKDHS county ~~worker~~Social Services Specialist completes and signs OKDHS form 02AG038E, ~~AG-17, Voluntary Action of Personal Care Case Closure form~~ADv-2, State Plan Personal Care/ADvantage Program Voluntary Withdrawal Request. The OKDHS nurse submits closure notification to the provider agency.

(e) **Resuming Personal Care services.** If a member approved for Personal Care services has been without Personal Care services for less than 90 days but still has a current ~~Personal Care services~~ medical and SoonerCare financial eligibility approval, Personal Care services may be resumed using the member's previously approved ~~Service Authorization Model (SAM)~~SAM packet. The Personal Care ~~service~~provider agency submits a Personal Care services skilled nursing re-assessment of need within ten working days of the resumed plan start date using the State Plan Personal Care Progress Notes, OKDHS form 02AG044E. If the member's needs dictate, the Personal Care ~~services~~provider agency may submit a request for a change in

authorized Personal Care services units with a ~~Service Authorization Model (SAM)~~SAM packet to OKDHS.

(f) **Financial ineligibility.** ~~Anytime~~When the OKDHS determines a Personal Care services member does not meet the SoonerCare financial eligibility criteria, the ~~local~~ OKDHS office notifies the ~~member, Personal Care service provider, and the OKDHS nurse of financial ineligibility.~~OKDHS area nurse to initiate the closure process due to financial ineligibility. Individuals determined financially ineligible for Personal Care services are notified by OKDHS in writing of the determination and of their right to appeal the decision. The OKDHS nurse submits closure notification to the provider agency.

(g) **Closure due to medical ineligibility.** ~~If the local OKDHS office is notified through the system that a member is no longer medically eligible for Personal Care, the OKDHS county worker notifies the member of the decision. The OKDHS nurse notifies the Personal Care service agency.~~Individuals determined medically ineligible for Personal Care services are notified by OKDHS in writing of the determination and of their right to appeal the decision. The OKDHS nurse submits closure notification to the provider agency.

(h) **Termination of State Plan Personal Care Services.**

(1) Personal Care services may be discontinued if:

(A) the member poses a threat to self or others as supported by professional documentation; or

(B) other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat ~~of harm or injury~~ to the member or other household visitors; or

(C) the member or family member fails to cooperate with Personal Care service delivery or to comply with OHCA or OKDHS rules as supported by professional documentation; or

(D) the member's health or safety is at risk as supported by professional documentation; or

(E) additional services, either "formal" (i.e., paid by SoonerCare or some other funding source) or "informal" (i.e., unpaid) are provided in the home eliminating the need for SoonerCare Personal Care services~~.~~; or

(F) the individual's living environment poses a physical threat to self or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible; or

(G) the member refuses to select and/or accept the services of a provider agency or PCA for 90 consecutive days as supported by professional documentation.

~~(2) The member refuses to select and/or accept the services of a Personal Care service agency or PCA for 90 consecutive days as supported by professional documentation.~~

~~(3)~~(2) For persons receiving Personal Care services, the Personal Care ~~services~~provider agency submits documentation with the recommendation to discontinue services to OKDHS. The OKDHS nurse reviews the documentation and submits it to the OKDHS Area Nurse for determination. The OKDHS nurse notifies ~~the member and~~ the Personal Care ~~service~~provider agency or PCA, and the local OKDHS county worker of the decision to terminate services. The member is sent an official closure notice informing them of their appropriate member rights to appeal the decision to discontinue services.

317:35-15-13.1. Individual Personal Care service management

(a) An ~~individual PCA~~IPCA may be utilized to provide ~~PC~~Personal Care services when it is documented to be in the best interest of the member to have an ~~individual personal care attendant (PCA)~~IPCA or when there are no qualified ~~PC service~~Personal Care provider agencies available in the member's local area. ~~When an individual PCA is utilized, the OKDHS nurse explains OHCA form HCA-66, Authorization for Withholding of FICA Tax in Personal Care, to the member and obtains his/her signature.~~ OHCA will check the list of providers that have been barred from Medicare/Medicaid participation to ensure that the ~~individual provider~~IPCA is not listed.

(b) After ~~PC~~Personal Care services eligibility is established and prior to implementation of ~~PC~~Personal Care services using an ~~individual PAC~~IPCA, the OKDHS nurse reviews the care plan with the member and ~~individual PCA~~IPCA and notifies the member and ~~PCA~~IPCA to begin ~~PC~~Personal Care services delivery. The OKDHS nurse maintains the original care plan and forwards a copy of the care plan to the ~~chosen PCA~~selected IPCA and member within one working day of ~~notice~~receipt of approval.

(c) The OKDHS nurse contacts the member within five working days to ensure services are in place and meeting the member's needs and also monitors the care plan for members with an ~~individual PCA~~IPCA. For any member receiving ~~PC~~Personal Care services utilizing an ~~individual PCA~~IPCA, the OKDHS nurse makes a home visit at least every ~~180 days~~six months beginning within 90 days of the date of ~~PC~~Personal Care service initiation. OKDHS assesses the member's satisfaction with their ~~PC~~Personal Care services

and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan must be approved by the OKDHS area nurse, or designee, prior to implementation of the changed number of units.

~~(d) If a member requires an individual PCA and is also approved for ADvantage waiver, the ADvantage case manager develops and monitors PC service delivery as part of the ADvantage service plan. The ADvantage case manager reviews the care plan with the member and forwards a copy to the individual PCA. The ADvantage case manager contacts the member within five calendar days of service plan certification by the AA in order to make sure that services have been implemented. The ADvantage case manager contacts the member within 30 calendar days of service plan certification by the AA in order to make sure the needs of the member are being met. Requests for changes in authorized PC services units are submitted by the ADvantage case manager for approval or denial by the AA or designee, prior to implementation of the changes in units. The ADvantage case manager contacts the member monthly and makes a home visit at least every 90 days to evaluate the care plan for adequacy of goals and units allocated.~~

~~(e) With the exception of members served by the ADvantage or any other Home and Community Based Services (HCBS) Waiver, the OKDHS nurse is responsible for assessing and monitoring the provision of personal care for Individual Personal Care members. This function involves advocacy, service planning, coordination, monitoring and problem solving with service providers and with families in the provision of services.~~

~~(f) Under certain circumstances, the use of informal supports as individual PCAs may be the only available option for providing services to the member. The ADvantage Program consumer's interdisciplinary team authorizes the use of informal supports for the PC program.~~

~~(1) Components built into the care plan to prevent failure/burnout of informal supports may include, but are not limited to, the following:~~

~~(A) utilization of additional informal supports, other than the one providing PCA services; and~~

~~(B) provision of home-delivered meals, adult day care, or PC services by an agency.~~

~~(2) The ADvantage Program case manager routinely reviews the care plan to ensure the services authorized meet the member's needs and to assess the stability of the informal support system. For members who receive services from an individual PCA, the case manager may increase the frequency of these reviews.~~

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

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

(1) **Payment for ~~Personal Care~~IPCA.** Payment for Personal Care services is ~~generally~~ made for care provided in the member's "own home" or in other limited types of living arrangements in accordance with OAC 317:35-15-2(b)(1 through 4). ~~A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., does not constitute a suitable substitute home. Personal Care may not be approved if the member lives in the PCA's home except with the interdisciplinary team's written approval. The potential individual PCA must meet the minimum requirements under (2) of this subsection. With OKDHS area nurse approval, or for ADvantage waiver members, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the service plan.~~

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

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

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

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

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

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

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

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

(2) **Member selection of ~~individual PCA~~IPCA**. Members and/or family members recruit, interview, conduct reference checks, and select the individual to be considered as an ~~individual contractor~~IPCA. Prior to placing a Personal Care service provider in the member's home, an OSBI background check and registry check must be completed in accordance with Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. The OKDHS ~~LTC~~ nurse must also check the Certified Nurse ~~Aid~~Aide Registry. The OKDHS ~~LTC~~ nurse must affirm that the applicant's name is not contained on any of the registries. The ~~LTC~~OKDHS nurse will notify the OHCA if the applicant is on the registry.

(A) **Persons eligible to serve as individual Personal Care Assistants.** Payment is made for Personal Care Services to ~~an individual who:~~IPCAs who provide Personal Care services who also meet the criteria as defined in OAC 317:35-15-2(c)(1 through 8).

~~(i) is at least 18 years of age,~~

~~(ii) has no pending notation related to abuse, neglect or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry,~~

~~(iii) has no criminal background history or registry listings that prohibit employment,~~

~~(iv) demonstrates the ability to understand and carry out assigned tasks,~~

~~(v) is not a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the member being served,~~

~~(vi) has a verifiable work history and/or personal references, verifiable identification, and~~

~~(vii) meets any additional requirements as outlined in the contract and certification requirements with the Oklahoma Health Care Authority.~~

(B) **Persons ineligible to serve as ~~Personal Care Assistants~~IPCAs.** Payment from SoonerCare funds for Personal Care services may not be made to an individual who is a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the member ~~to whom he/she is providing personal care services~~being served (exceptions to legal guardian are made only with prior approval from Aging Services Division).

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

(ii) If it is determined that an OKDHS or OHCA employee is interfering in the process of providing Personal Care ~~Services~~services for personal or family benefit, he/she will be subject to disciplinary action.

(3) **Orientation of the ~~Personal Care Assistant~~IPCA.** When a member selects an ~~individual PCA~~IPCA, the ~~LTC~~OKDHS nurse contacts the individual to report to the county office to

complete the ~~ODH~~Oklahoma State Department of Health form 805, Uniform Employment Application for Nurse Aide Staff, and the OKDHS form 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation. ~~This~~For Personal Care members, this process is the responsibility of the ~~LTC~~OKDHS nurse. The ~~PCA~~IPCA can begin work when:

(A) he/she has been interviewed by the member,

(B) he/she has been oriented by the ~~LTC~~OKDHS nurse,

(C) he/she has executed a contract (OHCA-0026) with the OHCA,

(D) the effective service date has been established,

(E) all registries have been checked and the ~~PCA's~~IPCA's name is not listed,

(F) the Oklahoma State Department of Health Nurse Aide Registry has been checked and no notations were found, and

(G) the OSBI background check has been completed.

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

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

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

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

(i) ~~a PCA's~~an IPCA's performance is such that his/her continued participation in the program could pose a threat to the health and safety of the member or others; or

(ii) the ~~PCA~~IPCA failed to comply with the expectations outlined in the PCA Provider Agreement and counseling is not appropriate or has not been effective; or

(iii) ~~a PCA's~~an IPCA's name appears on the OKDHS Community Services Worker Registry, any of the registries listed in Section 1-1947 of Title 63 of the

Oklahoma Statutes, even though his/her name may not have appeared on the Registry at the time of application or hiring.

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

(C) When the problem is related to allegations of abuse, neglect or exploitation, the ~~LTC~~OKDHS nurse follows the process as outlined in OAC 340:100-3-39.

317:35-15-14. Billing procedures for Personal Care

Billing procedures for Personal Care Services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the OHCA. Contractors for Personal Care bill on CMS-1500. The ~~OKDHS county office~~OHCA provides instructions to an ~~individual PCA~~IPCA for completion of the claim at the time of the contractor orientation. ~~Each Personal Care contractor~~The contracted provider submits a claim for each member. The ~~contractor~~contracted provider prepares claims for services provided and submits the claims to the fiscal agent who is responsible for assuring that the claims have been properly completed. All Personal Care contractors must have a unique provider number. New ~~contractors~~contracted providers will be mailed the provider number after they have been placed on the claims processing contractor's provider file. Service time of Personal Care and Nursing is documented solely through the Interactive Voice Response Authentication (IVRA) system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their provider agency backup plan. The provider agency's backup procedures are only permitted when the IVRA system is unavailable.

317:35-15-15. Referral for social services

In many situations, ~~adults~~members who are receiving medical services through SoonerCare need social services. The OKDHS nurse may make referrals for social services to the OKDHS worker in the

local office. In addition to these referrals, a request for social services may be initiated by a member or by another individual acting upon behalf of a member.

(1) The OKDHS ~~county worker~~Social Services Specialist is responsible for providing the indicated services or for referral to the appropriate resource outside the Department if the services are not available within the Department.

(2) Among the services provided by the OKDHS ~~worker~~Social Services Specialist are:

(A) Services that will enable individuals to attain and/or maintain as good physical and mental health as possible;

(B) Services to assist patients who are receiving care outside their own homes in planning for and returning to their own homes or to other alternate care;

(C) Services to encourage the development and maintenance of family and community interest and ties;

(D) Services to promote maximum independence in the management of their own affairs;

(E) Protective services, including evaluation of need for and arranging for guardianship; and

(F) Appropriate family planning services, which include assisting the family in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 64. CLINIC SERVICES

317:30-5-579. Prescription drugs purchased under the 340B Drug Discount Program provided by Clinics

For 340B Drug Discount Program guidelines refer to section 317:30-5-87.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES

317:30-5-134. Nurse Aide Training Reimbursement

(a) Nurse Aide training programs and competency evaluation programs occur in two settings, a nursing facility setting and private training courses. Private training includes, but is not limited to, certified training offered at vocational technical institutions. This rule outlines payment ~~for training~~ to qualified nurse aides trained in either setting.

(b) In the case a nursing facility provides training and competency evaluation in a program that is not properly certified under federal law, the Oklahoma Health Care Authority may offset the nursing facility's payment for monies paid to the facility for these programs. Such action shall occur after notification to the facility of the period of non-certification and the amount of the payment by the Oklahoma Health Care Authority.

(c) In the case of nurse aide training provided in private training courses, reimbursement is made to nurse aides who have paid a reasonable fee for training in a certified training program at the time training was received. The federal regulations prescribe applicable rules regarding certification of the program and certification occurs as a result of certification by the State Survey Agency. For nurse aides to receive reimbursement for private training courses, all of the following requirements must be met:

(1) the training and competency evaluation program must be certified at the time the training occurred;

(2) the nurse aide has paid for training;

(3) a reasonable fee was paid for training (however, reimbursement will not exceed the maximum amount set by the Oklahoma Health Care Authority of 800 dollars);

(4) the Oklahoma Health Care Authority is billed by the nurse aide receiving the training within 12 months of the completion of the training~~;~~. Reimbursement requests outside the first 12 months are not compensable;

(5) the nurse aide has passed her or his competency evaluation; and

(6) the nurse aide is employed at a SoonerCare contracted nursing facility as a nurse aide during all or part of the year after completion of the training and competency evaluation.

~~(d) If all the conditions in subsection (c) are met, then the Authority will compensate the nurse aide based upon the following pro-rata formula:~~

~~(1) For every month employed in a nursing facility, OHCA will pay 1/12 of the sum of eligible expenses incurred by the nurse aide. The term "every month" is defined as a period of 16 days or more within one month.~~

~~(2) The maximum amount paid by the Oklahoma Health Care Authority may be set by the Rates and Standards Committee. The rate paid by the nurse aide, up to the maximum set by the Oklahoma Health Care Authority, will be paid in the event a nurse aide was employed all 12 months after completion of the training program.~~

~~(e) The claimant must submit a completed Nurse Aide Training Reimbursement Program Form and ADM-12 claim voucher. Documentation of eligible expenses must also be provided. Eligible expenses include course training fees, textbooks and exam fees.~~

~~(f) No nurse aide trained in a nursing facility program that has an offer of employment or is employed by the nursing facility in any capacity at the inception of the training program may be charged for the costs associated with the nurse aide training or competency evaluation program.~~

~~(g) The SoonerCare share of Nurse Aide training and testing costs incurred by a nursing facility will be reimbursed in the following manner:~~

~~(1) Quarterly, the facilities incurring expense and requesting reimbursement for the Medicaid share of Nurse Aide Training costs will complete and file a "Nurse Aide Training and Testing Costs" report as prescribed by the OHCA. These reports will be due by the end of the subsequent month.~~

~~(2) From the "Nurse Aide Training and Testing Costs" reports the OHCA will determine a cost per day for each facility for the period.~~

~~(3) The OHCA will pay each facility based on the reported cost per day applied to the actual SoonerCare paid days that matches the period reported by the facility.~~

~~(4) Nurse Aide Training Costs are not allowable for cost reporting purposes.~~

(d) If all the conditions in subsection (c) are met, then the Authority will compensate the nurse aide on a quarterly basis. For every qualifying month employed in a nursing facility during a quarter, OHCA will pay the previous quarter's sum of eligible expenses incurred by the nurse aide. The term "qualifying month" is defined as a period of 16 days or more within one calendar month. The terms "quarter" and "quarterly basis" are defined as three qualifying months.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 62. PRIVATE DUTY NURSING

317:30-5-559. How services are authorized

An eligible provider may have private duty nursing services authorized by following all the following steps:

(1) create a treatment plan for the patient as expressed in OAC 317:30-5-560;

(2) submit the prior authorization request with the appropriate OHCA required forms, the treatment plan, and request the telephonic interview and/or personal visit by an OHCA Care Management Nurse; and

(3) have an OHCA ~~Care Management Nurse~~physician determine medical necessity of the service ~~by~~including scoring the member's needs on the Private Duty Nursing Acuity Grid.

317:30-5-560. Treatment Plan

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing services. The initial treatment plan must be signed by the member's attending physician.

(b) The treatment plan must include all of the following medical and social data so that an OHCA ~~Care Management Nurse~~physician can appropriately determine medical necessity ~~by the~~including use of the Private Duty Nursing Acuity Grid:

(1) diagnosis;

(2) prognosis;

(3) anticipated length of treatment;

(4) number of hours of private duty nursing requested per day;

(5) assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory);

(6) medication method of administration and frequency;

(7) age-appropriate feeding requirements (diet, method and frequency);

(8) respiratory needs;

(9) mobility requirements including need for turning and positioning, and the potential for skin breakdown;

(10) developmental deficits;

(11) casting, orthotics, therapies;

(12) age-appropriate elimination needs;

(13) seizure activity and precautions;

(14) age-appropriate sleep patterns;

(15) disorientation and/or combative issues;

(16) age-appropriate wound care and/or personal care;

(17) communication issues;
(18) social support needs;
(19) name, skill level, and availability of all caregivers; and
(20) other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

(a) Authorizations are provided for a maximum period of six months.

(b) Authorizations require:

(1) a treatment plan for the member; ~~and~~

(2) a telephonic interview and/or personal visit by an OHCA Care Management Nurse ~~to determine medical necessity using the Private Duty Nursing Acuity Grid.~~; and

(3) an OHCA physician to determine medical necessity including use of the Private Duty Nursing Acuity Grid.

(c) The number of hours authorized may differ from the hours requested on the treatment plan based on the ~~assessment of the Care Management Nurse~~review by an OHCA physician.

(d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.

(e) Changes in the treatment plan may necessitate another telephonic interview and/or personal visit by the OHCA Care Management staff.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-14. Freedom of choice

(a) **Any Qualified provider.** The ~~Medicaid Agency~~Oklahoma Health Care Authority (OHCA) assures that any individual eligible for ~~Medicaid~~SoonerCare, may obtain services from any institution, agency, pharmacy, person, or organization that is contracted with OHCA and qualified to perform the services.

(b) **~~Recipient~~Member lock-in.** ~~Medicaid recipients~~SoonerCare members who have demonstrated ~~Medicaid usage~~utilization above the statistical norm, during a ~~12-month~~6-month period, may be "locked-in" to ~~one primary physician~~a prescriber and/or one pharmacy for medications classified as controlled dangerous substances in accordance with Federal Regulation 42 CFR 431.54.

(1) Over-utilization patterns by ~~Medicaid recipients~~SoonerCare members may be identified either by referral or by OHCA automated computer systems. ~~Medicaid~~SoonerCare records, for a ~~12-month~~6-month period, of those identified ~~recipients~~members are then reviewed. ~~Medical histories are ordered and~~Medical and pharmacy claim histories are reviewed by OHCA ~~medical~~pharmacy consultants to determine if high usage is medically justified.

(2) If it is determined that ~~Medicaid~~SoonerCare has been over-utilized, the ~~recipient~~member may be notified, by letter, of the need to select a ~~primary physician~~prescriber and/or pharmacy and of their opportunity for a fair hearing. If they do not select a ~~physician~~prescriber or pharmacy one is selected for them. ~~The primary-care provider must be a general practice, family practice, OB-GYN, pediatrician or internal-medicine physician and currently be enrolled as a Medicaid provider.~~ In some cases ~~recipients~~members may be sanctioned under OAC 317:35-13-7.

(3) The ~~provider~~prescriber and/or pharmacy of choice, unless ~~that provider has~~the aforementioned providers have been identified as having problems with ~~Medicaid~~ over-utilization, ~~is~~are notified by letter and ~~is~~ given an opportunity to accept or decline to be the ~~recipient's primary physician~~member's prescriber and/or pharmacy.

(4) When the provider accepts, a confirmation letter is sent to both ~~recipient~~member and provider showing the effective date of the arrangement. ~~The recipient will be issued a monthly Medicaid identification card which will designate them as a participant in the lock-in program.~~

(5) After the lock-in arrangement is made, the provider may file claims for services provided in accordance with OHCA ~~procedure~~guidelines.

(6) Locked-in ~~recipients~~members may obtain emergency services from an emergency room facility for an emergency medical condition or as part of an inpatient admission.

~~(7) Medicaid-compensable visits to a specialist are covered when referred by the primary-care physician. The primary-care physician must be shown as the referring physician on Item 17 of HCFA-1500 submitted by the specialist.~~

~~(8)~~(7) If a claim for a controlled dangerous substance is filed by another ~~provider~~pharmacy, ~~it is reviewed to see if a referral was given or services were for an acute physical injury. Claims not meeting this criteria are denied and the recipient is responsible for charges~~the claim will be denied.

~~(9)~~(8) When a ~~recipient~~member is enrolled into the lock-in program, usage is monitored ~~when necessary~~periodically and reviewed every 24 months. A provider may send a written request for ~~recipient~~member review. If review indicates utilization patterns meet lock-in removal criteria, the ~~recipient~~member may be removed from lock-in at the discretion of OHCA staff.

~~(10)~~(9) During a review, OHCA may elect to continue lock-in, remove the ~~recipient~~member from lock-in because of medical necessity, remove them because of decreased utilization, or impose sanctions under OAC 317:35-13-7.

~~(11)~~(10) The ~~recipient~~member in the lock-in program may make a ~~written~~ request to change providers after the initial three months; when the ~~recipient~~member moves to a different city or if the ~~recipient~~member feels irreconcilable differences will prevent necessary medical care. Change of providers based on irreconcilable differences must be approved by OHCA staff or contractor.

~~(12)~~(11) OHCA may make a provider change when the provider makes a ~~written~~ request for change or may initiate a change anytime it is determined necessary to meet program goals.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-1. ~~Payment for Medicaid~~Reimbursement

(a) **Payment eligibility.** In order for the Authority to make payment for ~~Medicaid~~SoonerCare services, the individual must be determined eligible to have such payment made by:

(1) having eligibility previously determined, or

(2) making application for ~~Medicaid~~SoonerCare at the time the medical services is requested, and having eligibility determined at that time.

(b) **~~Recipient~~Member lock-in.** ~~Medicaid recipients~~SoonerCare members who have demonstrated ~~Medicaid usage~~utilization above the statistical norm, during a ~~12-month~~6-month period, may be "locked-in" to ~~one primary physician~~a prescriber and/or one pharmacy for medications classified as controlled dangerous substances. If OHCA has determined that ~~Medicaid~~SoonerCare has been over-utilized, the ~~recipient~~member is notified, by letter, of the need to select a ~~primary physician~~prescriber and/or pharmacy and of their opportunity for a fair hearing. ~~A copy of the letter is sent to the DHS county office.~~ If the ~~recipient~~member does not select a ~~physician and/or pharmacy~~prescriber or pharmacy, one is selected for her/him. "Locked-in" ~~recipients~~members may obtain emergency services from a physician and/or an emergency room facility in the event of a medical emergency.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.7. Free choice

A member has the choice of which provider will fill the prescription or order for a DMEPOS. ~~The prescribing physician should give the written prescription or order to the member in order to allow the member freedom of choice~~. All providers must inform the member they have a choice of provider when filling or ordering DMEPOS.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 7. SOONERCARE
PART 1. GENERAL PROVISIONS

317:25-7-7. Referrals for specialty services

(a) PCPs are required to assure the delivery of medically necessary preventive and primary care medical services, including securing referrals for specialty services. Some services, as defined in OAC 317:25-7-2(c) and OAC 317:25-7-10(b), do not require a referral from the PCP. A PCP referral does not guarantee payment, as all services authorized by the PCP must be in the scope of coverage of the SoonerCare Choice program to be considered compensable.

(b) Pursuant to OAC 317:30-3-1(f), SoonerCare Choice referrals must always be made on the basis of medical necessity. Referrals from the PCP are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP.

(c) ~~Documentation in the medical record must include a copy of each referral to another health care provider.~~ The PCP and specialty provider are responsible for maintaining appropriate documentation of each referral to support the claims for medically necessary services.

(d) As approved and deemed appropriate, the OHCA may provide administrative referrals for specialty services. Administrative referrals are only provided by the OHCA under special and extenuating circumstances. Administrative referrals should not be requested as a standard business practice. The OHCA will not process retrospective administrative referrals, unless one of the following exceptions applies:

(1) the specialty services are referred from an IHS, tribal, or urban Indian clinic;

(2) the specialty services are referred as the result of an emergency room visit or emergency room follow-up visit;

(3) the specialty services are referred for pre-operative facility services prior to a dental procedure; or

(4) the retrospective administrative referral request for specialty services is requested from the OHCA within 30 calendar days of the specialty care date of service. If the retrospective administrative referral is requested within the 30 calendar days, the request must include appropriate documentation for the OHCA to approve the request. Appropriate documentation must include:

(A) proof that the specialist has attempted to collect a PCP referral from the member's assigned PCP; and

(B) medical documentation to substantiate that the specialty services are medically necessary pursuant to OAC 317:30-3-1(f).

(e) Nothing in this section is intended to absolve the PCP of their obligations in accordance with the conditions set forth in their PCP SoonerCare Choice contract and the rules delineated in OAC 317:30.

January 2015 MAC
Proposed Rule Amendment Summaries

Information Only

The following are summaries of proposed rules. 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

14-05 Policy Change for Member Copayments — These rules were reviewed during the emergency rule process with the exception of the following proposed changes: policy is amended to add diabetic supplies and smoking cessation counseling and products to the service copayment exemption list in order to ensure member access to necessary services that improve member health outcomes.

14-07 Policy Change for Oxygen and Oxygen Equipment — Proposed oxygen and oxygen equipment policy is amended to require a prior authorization after the initial three months. In addition, rules are revised to clarify arterial blood gas analysis (ABG) and pulse oximetry testing and Certificate of Medical Necessity requirements. Rules for rental oxygen are amended to clarify that reimbursement for rented oxygen concentrators includes both stationary and portable oxygen systems.

14-14A&B 1915(c) Conflict of Interest — The proposed 1915(c) Conflict of Interest policy is amended to ensure all 1915(c) waiver programs comply with 42 CFR 441.301 regarding conflict of interest provisions for case management services. These policy revisions 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.

14-17 Moving to an SSI Criteria State for Determining Medicaid Eligibility for Aged, Blind, and Disabled (ABD) Individuals — These rule changes have already been reviewed during the emergency rule process with the exception of the following proposed changes: rules regarding income received from capital resources and rental property are amended to deduct the severance tax from the gross income for ABD applicants. Rules regarding infrequent or irregular income are amended to better match the Social Security Administration rules for determining Supplemental Security Income.

14-19A&B Transition of Waivers — The OHCA is exploring options by revoking all policy to transition the operational functions of its internal 1915c Waiver services and responsibilities. The two (2) internal waivers include: (a) My Life My Choice and (b) Sooner Seniors. 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.

14-20 Hospital Presumptive Eligibility — The proposed Hospital Presumptive Eligibility (HPE) rules are added to comply with Section 1920A of the Act and federal regulations 42 CFR 435.1100-1110. HPE allows participating hospitals to make presumptive eligibility (PE) determinations, on behalf of the agency, for applicants who are deemed eligible for Medicaid services based on preliminary information provided by the applicant. Hospitals may then provide services under HPE and bill OHCA. Hospitals are guaranteed payment for HPE services, regardless of whether or not the applicant is later found eligible for SoonerCare. The rules will

delineate the parameters of the HPE program, eligibility guidelines, and hospital participation rules.

14-23 Department of Labor — The proposed policy is amended to ensure all Developmental Disabilities Services (DDS) comply with 29 CFR 552.109 regarding domestic service employees employed by third-party employers, or employers other than the individual receiving services, or his or her family, or household. The regulation precludes third party employers from claiming the companion exemption.

14-25 Dental — The proposed dental policy is amended to align practice with the Code on Dental Procedures and Nomenclature (CDT) and to ensure the delivery of dental services meets the standard of care. Proposed revisions include guidelines for x-rays, comprehensive and periodic oral evaluations, and dental sealants. Rules are revised to add coverage for the replacement of sealants; current policy restricts coverage for replacement sealants when medically necessary. Revisions also include clean-up to remove language regarding composite and amalgam restorations as it is referenced in a different section. Proposed revisions outline guidelines for stainless steel crowns to clarify that placement is allowed once for a minimum period of 24 months as well as other clean-up for clarity.

In addition, policy is revised to ensure root canal therapy is performed only when medically necessary. Proposed revisions clarify utilization parameters for restorations, observation time prior to making a referral for an orthodontic consultation, and the start of the treatment year for orthodontic services. Policy is revised to clarify the treatment year for orthodontic services begin on the date of the placement of the bands. Orthodontic policy is also revised to increase observation time prior to allowing a child to be referred for a consultation.

14-36 Long-term Care Eligibility — The proposed Long-term Care Eligibility rules are amended to align with 42 U.S. Code §1396p. Proposed revisions include increasing home equity maximum amount to $500,000 plus the increase by the annual percentage increase in the urban component of the consumer price index and allowing the individual to decrease this equity interest through the use of a reverse mortgage or home equity loan. The term "relative" is removed from the home exemption rules for members who fail to return back home from a long-term care institution. The term "annuity" is changed to also include annuities purchased by, or on behalf of, an annuitant seeking long-term care services.

14-46A&B Developmental Disabilities Services (DDS) — The proposed revisions are to implement policy changes recommended during the Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) annual policy review process. Additional policy was added to include specific educational qualifications and requirements for service providers. The recommendation revisions will also assist DDS with being in full compliance with the new federal regulation for Home and Community-Based Services with regard to members and their settings. Oklahoma Administrative Code (OAC) Section 317: 40-1-3 was also added to comply with federal regulation. Additionally, the proposed policy revisions will position DDS to utilize best practice in the administration of the statewide Request for Waiver Services list.

14-49A&B Insure Oklahoma Eligibility — Policy is proposing the change to the Modified Adjusted Gross Income methodology for Insure Oklahoma IP and ESI eligibility groups. The proposed change will enhance the eligibility process for Insure Oklahoma enrollees. This change will align the eligibility methodology for the IO program with that of SoonerCare and allow the Agency to move the IO program to the Online Enrollment platform to enroll members. The reasonable opportunity for SoonerCare members to obtain citizenship or alienage documentation will also be amended.

14-50 Telemedicine — The proposed telemedicine rules is amended to clarify the definition for telemedicine, and to remove the "Definitions" sections for consistency. Proposed changes also remove coverage guidelines to expand the scope of the telemedicine delivery method. Revisions remove requirements for a presenter at the distant site to align with the Oklahoma Medical Licensure rules, and guidelines regarding the required use of OHCA-approved telemedicine networks. Proposed revisions also eliminate the originating site fee payment. Additional clean-up ensures that there are no restrictions for services rendered using the telemedicine delivery model.

14-52A&B SoonerRide — Proposed SoonerRide policy is amended to remove reference to inpatient under the exclusion group for SoonerRide eligibility, as this is not considered an eligibility standard. Rules also remove coverage for transport to state Veterans Affair hospitals as these facilities are not contracted with the Oklahoma Health Care Authority. Rules also clarify coverage guidelines for escorts.

14-58 High Risk Obstetrical Services — Proposed rules for high risk obstetrical (HROB) services are amended to increase access in rural areas. Currently high risk obstetrical services are allowed only after an evaluation with Maternal Fetal Medicine doctor and the member is deemed high risk; enhanced services are allowed, only after a prior authorization request and treatment plan are initiated and submitted by the MFM. The initial intent of the HROB program was to promote the establishment of a relationship between the MFM's in urban areas with mothers located in rural communities. However, it appears that pregnant women rural communities rarely travel to the urban areas to receive services. Allowing the general OB to request the HROB services/package for pregnant women will allow ensure pregnant women with high risk conditions receive HROB services.

14-60 Federal Qualified Health Centers (FQHC) — Proposed rules are amended to allow FQHCs to be reimbursed at the PPS rate immediately upon receiving their Health Resources and Services Administration (HRSA) grant award letter. Currently, OHCA requires the facility to submit the award letter and their Medicare certification number. In the interim, facilities contract as a clinic and are paid the fee for service (FFS) rate.

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14-13 Psychosocial rehabilitation (PSR) Service Eligibility Criteria — These rules have already been reviewed during the emergency rule process with the exception of the following proposed changes: revisions to outpatient behavioral health rules to clarify that daily or weekly summary notes and related requirements are for rehab day programs only, to create distinction between licensed behavioral health professionals and licensure candidates, to clarify that group psychotherapy is not reimbursable, and other grammatical changes.

14-15 Behavioral Health Outpatient Billable Hours — Proposed rules are amended to limit the number of hours that outpatient behavioral health rendering providers can be reimbursed to 35 hours per week. Additionally, rules are revised to indicate that testing for a child younger than three is not allowed; this change is to correct scrivener’s errors made during the 2014 permanent rulemaking session.

14-39 Therapeutic Foster Care — Proposed policy is amended to indicate a 1.5 hours daily limit on services billed by the Treatment Parent Specialist (TPS) within the Therapeutic Foster Care (TFC) setting. This change in policy aligns with limitations delineated within the State Plan for this particular provider and setting. Additionally, rules are revised to make a distinction between LBHPs and Licensure Candidates.

14-45 Psychiatric Residential Treatment Programs Staffing Ratios — Proposed inpatient psychiatric hospital policy is amended to indicate that non-specialty Psychiatric Residential Treatment Facilities (PRTF) should have a staff to member ratio of 1:6 during routine awake hours and 1:8 during sleeping hours. Additionally, changes are made to clarify that staffing ratios should always be present for each individual unit not by facility or program. Other minor grammatical changes were made to the rule.

14-47 First Visit by the Physician in Active Treatment — Proposed policy is amended to indicate that when the H&P or a combined H&P and psychiatric evaluation are completed by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, the assessment(s) may count as the first visit by the physician in active treatment. Additionally, rules are revised to include a distinction between LBHPs and Licensure Candidates.

14-48 Targeted Case Management (TCM) — Proposed policy is amended to add the State Plan authorized billing limits of 25 units per month for regular TCM and 54 units for intensive TCM. Rules are also amended to create a distinction between LBHPs and licensure candidates. Additionally, rules are revised to include CM II certification requirements; this change in rules is to correct scrivener's errors made during the 2014 permanent rulemaking session.

14-53 Mental Health Substance Use Screenings — Proposed policy is amended to add service coverage for mental health/substance use disorder screening for SoonerCare adult and child members within an outpatient behavioral health agency setting. Additionally, rules are revised to create a distinction between LBHPs and Licensure Candidates.

14-55 Distinction between LBHP & Licensure Candidate — Proposed outpatient behavioral health rules are amended to create distinction between licensed behavioral health professionals and licensure candidates. Additionally, other minor grammatical errors were corrected and outdated references were removed.