OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
August 25, 2010 at 4:00PM
Reed Conference Center
5800 Will Rogers Road
Midwest City, OK

A G E N D A

Items to be presented by Lyle Roggow, Chairman

1. Call To Order/Determination of quorum
2. Action Item – Approval of July 8, 2010 Board Minutes

Item to be presented by Mike Fogarty, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) Financial Update – Carrie Evans
   b) Medicaid Director's Update – Garth Splinter, M.D.

Item to be presented by Chairman Roggow

4. Discussion Item – Reports to the Board by Board Committees

   a) Audit/Finance Committee – Member Miller
   b) Rules Committee – Member McVay

Item to be presented by Howard Pallotta, Director of Legal Services

5. Announcement of Conflicts of Interest Panel Recommendations for all action items regarding this board meeting.

Items to be presented by Cindy Roberts, Deputy Chief Executive Officer

6. Action Item – Consideration and Vote of agency recommended rulemaking pursuant to Article I of the Administrative Procedures Act.

   a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of ***all Emergency Rules*** in accordance with 75 Okla. Stat. § 253.

   b) Consideration and Vote Upon promulgation of ***Emergency Rules*** as follows:

   6.b-1 AMENDING Agency rules at OAC 317:30-5-660, 30-5-660.1, 30-5-660.3 through 30-5-660.5, 30-5-661.1, 30-5-661.4, 30-5-661.5, 30-5-661.7, 30-5-664.3, 30-5-664.5, 30-5-664.7, 30-5-664.10 and REVOKING Agency rules at OAC 317:30-5-664.11 to clarify reimbursement for certain Licensed Behavioral Health Professionals in Federally Qualified Health Centers

6.b-1**(continued)(**FQHC's). Additionally, revisions are made to reflect contracting and reimbursement requirements for covered services in FQHC's and school settings. Policy revisions are needed to make certain Licensed Behavioral Health Professional's(LBHP's) who provide behavioral health services in FQHC's are reimbursed appropriately. Revisions are also needed to identify behavioral health services that are permissible in FQHC's and school settings. These revisions ensure that the reimbursement rates for services rendered in FQHC's comply with cost based reimbursement accounting principles thereby eliminating payment errors and guarding the Agency's Federal Financial Participation from being at risk.
(Reference APA WF # 10-04)

6.b-2 ADDING Agency rules at OAC 317:45-13-1 to add dental services requirements and benefits for children in the Insure Oklahoma Program. The Oklahoma Health Care Authority (OHCA), as a requirement of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), will provide dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Rules will include requirements and benefits for direct dental coverage. The benefits extended to children will include class A, B, C, orthodontic care, and emergency dental services. All dental services for children will follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule.
(Reference APA WF # 10-32)

6.b-3 ADDING Agency rules at OAC 317:50-5-1 through 50-5-16 to include language allowing for a new Home and Community Based Services Waiver program known as Sooner Seniors. The Sooner Seniors Waiver is targeted to members who are age 65 or older, have a clinically documented degenerative disease process and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional services in a home setting. The program is more cost effective than institutionalized care; therefore a substantial savings will be realized over time through operation of this Waiver.
(Reference APA WF # 10-40)

6.b-4 ADDING Agency rules at OAC 317:50-3-1 through 50-3-16 to include language allowing for a new Home and Community Based Services Waiver program known as My Life, My Choice. The My Life, My Choice Waiver is targeted to members who are 20 to 64 years of age, are physically disabled and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional

6.b-4 **(continued)** services in a home setting. The program is more cost effective than institutionalized care; therefore a substantial savings will be realized over time through operation of this Waiver.
(Reference APA WF # 10-41)

Item to be presented by Beth VanHorn, Director of Legal Operations

7. a) Action Item - Consideration and Vote for Authorization to Expend Funds for the Medical Management Information System (MMIS) Reprocurement

Item to be presented by Chairman Roggow

8. Discussion Item - Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Okla. State. §307(B)(1),(4)&(7)

Status of pending suits and claims

1. OKAAP v. OHCA – 05-5100 and 05-5107 (10th Circuit Ct. of Appeals)
2. Price v. Wolford – CIV-07-1076M (USDC Western District)
3. Ass'n. for Direct Care Trainers v. OHCA – CJ-08-4237 (Oklahoma County)
4. Morehead v. OHCA, No. CJ-07-1110-L (Cleveland County).
5. Covalt v. DHS – CJ-08-85 (Grant County)
6. Morris v. OKDHS – CIV-09-1357C (USDC, Western District)
7. Wright v. OHCA – CJ-09-3924 (Oklahoma County)
8. US v. Wyeth – 03-12366-DPW and 06-11724-DPW (D. Massachusetts)
9. Kim Holland, Ins. Comm. v. OHCA – 108,519 (Okla. S.Ct.)

RECESS

RECONVENE BOARD MEETING/RETREAT 8:30 a.m. THURSDAY, AUGUST 26, 2010
REED CONFERENCE CENTER

THE FOLLOWING ITEMS WILL FOLLOW RETREAT FORMAT OF PANEL DISCUSSION AND OPEN DISCUSSION: ITEMS (9) THROUGH (19) ARE DISCUSSION ITEMS ONLY

THURSDAY
Registration Open (8:00am)

9. **Welcome/Opening Remarks –** Lyle Roggow, OHCA Board Chairman and Mike Fogarty, Chief Executive Officer, OHCA

10. **Session I - OHCA Overarching Goals & Agenda Highlights**

Presenter: Cindy Roberts, Deputy Chief Executive Officer, OHCA

11. **Session II - Oklahoma's Health/It's Everyone's Business**

Panelists:
Mike Fogarty, Chief Executive Officer, OHCA
Dr. Terry Cline, Commissioner, Oklahoma State Department of Health
Terri White, Oklahoma Secretary of Health, Commissioner of Mental Health and Substance Abuse Services

Networking Break

12. **Session III - National Health Care Reform/Changes are in store for Oklahoma…are we ready?**

Introduction
Becky Pasternik-Ikard, Deputy State Medicaid Director, OHCA

Presenters:
Chad Shearer, Senior Program Officer, Center for Health Care Strategies
Andrew Cohen, Director, Pacific Health Policy Group

Lunch Break 12:15pm – 1:30pm

13. **Session IV - Online Enrollment/Easy as 1-2-3 for SoonerCare members and partners**

Panelists:
Derek Lieser, Project/Planning Manager, OHCA
Richard Evans, Eligibility Automation and Data Integrity Manager, OHCA
Yvonne Myers, Chief, Federal Funds Development, Oklahoma State Department of Health
Jim Struby, Programs Administrator with Family Support Services Division, Oklahoma Department of Human Services
Tracy Jones, Chickasaw Nation Health System

14. **Session V Health - Insurance Exchanges in Oklahoma/The devil is in the details**

Panelists:
Deborah Chollet, Senior Fellow, Mathematica Policy Research Inc.
Mike Fogarty, Chief Executive Officer, OHCA
Kim Holland, Commissioner, Oklahoma Insurance Department

Networking Break

15. **Session VI - Health Information Technology (HIT)/Oklahoma's roadmap to the health information highway**

Presenters:
John Calabro, Chief Information Officer, OHCA
Adolph Maren, Planning Coordinator, OHCA
Melody Anthony, Provider Services Director, OHCA
Carol McFarland, Performance & Reporting Manager, OHCA

16. **Session VII - Last Call/Questions & Answers**

Facilitator:
Nico Gomez, Deputy Chief Executive Officer, OHCA

RECONVENE BOARD MEETING/RETREAT 8:30 a.m. FRIDAY, AUGUST 27, 2010
REED CONFERENCE CENTER
FRIDAY

Registration Open (8:00am)

17. **Session VIII - Oklahoma's Budget Outlook/Managing resources to maintain member services**

Presenters:
Carrie Evans, Chief Financial Officer, OHCA
Juarez McCann, Chief Budget Officer, OHCA
Stephen Weiss, Senior Financial Analyst, OHCA

Networking Break

18. **Session IV - The Patient Centered Medical Home/The business of serving our members**

Panelists:
Dr. Daniel Duffy, Dean, College of Medicine, University of Oklahoma – Tulsa, School of Community Medicine
Becky Pasternik-Ikard, Deputy State Medicaid Director, OHCA
Melody Anthony, Provider Services Director, OHCA
Patricia Johnson, Quality Assurance Director, OHCA
Marlene Asmussen, Care Management and Medical Authorization Director, OHCA
Kevin Rupe, Member Services Director, OHCA

19. **Session X - Last Call / Open Forum / Action Plan Review**

Facilitator:
Nico Gomez, Deputy Chief Executive Officer, OHCA

20. **Wrap-up / Closing Remarks –** Lyle Roggow, OHCA Board Chairman and Mike Fogarty, Chief Executive Officer, OHCA

21. New Business

22. **ADJOURNMENT**

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
July 8, 2010 at 1:02 P.M.
Held at Oklahoma State Capitol
2300 N. Lincoln Blvd.
Fourth Floor, Conference Room 419C
Oklahoma City, OK

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on June 9, 2010.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Roggow called the meeting to order at 1:00PM.

BOARD MEMBERS PRESENT:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member McVay, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp

OTHERS PRESENT:	OTHERS PRESENT:
Justin Martino, eCapitol	Nancy Kachel, PPAEO
Kay Welch, Hewlett Packard	Lisa Spain, Hewlett Packard
Cindy Fisk, Hewlett Packard	Anne Roberts, Integris
John Giles, OHCA	Traylor Rains, OHCA
Tywanda Cox, OHCA	Reginald McKnight, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD JUNE 10, 2010

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION:	Member McFall moved for approval of the June 10, 2010 board minutes as presented. Vice Chairman Armstrong seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp
ABSTAIN:	Member McVay

ITEM 3.a/FINANCIAL UPDATE
Gloria Hudson-Hinkel

Ms. Hinkel stated that the revenues for OHCA through May, accounting for receivables, were **$3,127,014,621** or **.3% over** budget. The expenditures accounting for encumbrances, were **$3,044,605,394** or **.5% over** budget. She reported that the state dollar budget variance through May is **$3,025,528 positive,** and the state dollar budget

variance due to Medicare Part D Stimulus allocation is **$21,082,315 positive.** The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(13.1)
Medicare Part D	21.1
Administration	4.5
Unbudgeted Carryover	3.4
Revenues:	
Taxes and Fees	4.0
Drug Rebate	.9
Overpayments/Settlements	3.3
Total FY 10 Variance	**$ 24.1**

ITEM 3.b/MEDICAID DIRECTOR'S UPDATE
Garth L. Splinter, M.D.,MBA

Dr. Splinter stated that with an overall enrollment total of 726,111 members in both SoonerCare and Insure Oklahoma (Soonercare 694,898 and Inure OK 31,213) we have experienced an increase of less than 2,500 members since April. However, Insure Oklahoma July 2010 enrollment numbers is 31,994 a slight increase of over 700. Dr. Splinter noted that the Employer Sponsored Insurance member enrollment has remained relatively flat since January 2010. Dr. Splinter said that we continue to monitor our contracted providers, particularly the SoonerCare Choice PCP network which continues to be stable with available capacity to serve additional members and has 1512 PCPs associates with 767 PCMH practice sites serving 433,655 SoonerCare Choice enrollees, which is an average panel size of less than 300 members. Dr. Splinter summarized the fast facts and noted that there was a new one today for your review, "The Opportunities for Living Life Fast Facts". He noted that at the June board meeting, the board approved rules related to the Medically Fragile Waiver Program, and I am pleased to report that on June 23rd, the OHCA received CMS approval. Dr. Splinter gave a brief update regarding the April 1 implementation of the tiered reimbursement methodology for the Psychiatric Residential Treatment Facilities. He stated that at this time the agency is compiling and analyzing the data thus far on the impact of this methodology and a large group meeting with impacted providers is being planned in August to review the findings.

ITEM 3.c/UPDATE ON RELOCATION OF STAFF
Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts reported that due to the storm damage that left uninhabitable working conditions, we have moved approximately 299 people to Shepherd Mall so far. OHCA is taking over the previous AOL call center space. She noted that this is quite different with a lot of PODS but very feasible temporarily. The space is also about 50,000 fewer square feet than what OHCA currently has at Lincoln Plaza. Ms.

Robert said that the remaining OHCA 279 employees will move from July 12 through July 19 and we anticipate being totally out by July 31. The staff has worked efficiently as always and has taken this as an opportunity to purge paper files. Also, this has been a great opportunity to get to know their fellow staff person a lot more intimately than before. Ms. Roberts noted that the MMIS and Human Resources staff has been amazing getting everyone's need resolved. Hewlett Packard (HP) has been gracious in providing space and also accommodating in other ways.

ITEM 4/REPORTS TO THE BOARD BY BOARD COMMITTEES
Chairman Roggow

Audit/Finance Committee
Member Miller

Member Miller stated the committee did meet and spent most of the time reviewing the Budget Work Program which Mr. McCann filed prior to July 1. Due to the priority for HealthCare given by the Legislature and Stimulus money received, we are not going to have to cut any medical services. Member Miller said there is no anticipation of cutting any payment rates, and the new programs have been funded. We are now serving 700,000 and are extremely grateful to the legislators for funding healthcare for the Oklahoma Health Care Authority.

Strategic Planning Committee
Cindy Roberts

Ms. Roberts reported that the committee did meet and discussed items related to the upcoming board retreat. She said that the theme of the retreat will be centered around the fact that everything we do is related to taking care of our members. We will look at our internal infrastructure, how we take care of our members, and opportunities as we move forward. Hopefully, the agenda will be posted soon on OHCA Website.

Rules Committee
Member McVay

Member McVay stated the committee did meet and reviewed the rules for action today.

ITEM 5/ ACTION ITEM – CONSIDERATION AND APPROVAL OF THE STATE FISCAL YEAR 2011 BUDGET WORK PROGRAM
Juarez McCann, Chief Budget Officer

Mr. McCann discussed in detail the fiscal year 2010 budget work program from a summary of expenditures. For a detailed report see **ITEM 5** of the Board packet.

MOTION:	Member Miller moved for approval of the Budget Work Program as presented. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member McFall, and Chairman Roggow

ABSENT: Member Langenkamp

ITEM 6 - ANNOUNCEMENTS OF CONFLICTS OF INEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING
Howard Pallotta, General Counsel

Mr. Pallotta stated that the Conflicts of Interest Panel met and found there were no conflicts regarding Items 7 and 8.

ITEM 7.a) CONSIDERATION AND VOTE UPON A DECLARATION OF A COMPELLING PUBLIC INTEREST FOR THE PROMULGATION OF ALL EMERGENCY RULES IN ACCORDANCE WITH 75 OKLA. STAT. § 253
Traylor Rains, Policy Development Coordinator

MOTION: Member McFall moved for approval of the June 10, 2010 board minutes as presented. Vice Chairman Armstrong seconded.

FOR THE MOTION: Vice Chairman Armstrong, Member Member Bryant, Member Miller, Member McFall, and Chairman Roggow

ABSENT: Member Langenkamp

ITEM 7.b) CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:
Traylor Rains, Policy Development Coordinator

7.b-1 through 7.b-3 as published in meeting agenda.

MOTION: Member McFall moved for approval of the June 10, 2010 board minutes as presented. Vice Chairman Armstrong seconded.

FOR THE MOTION: Vice Chairman Armstrong, Member Member Bryant, Member Miller, Member McFall, and Chairman Roggow

ABSENT: Member Langenkamp

ITEM 8 – CONSIDERATION AND VOTE UPON RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUES § 5030.3.
Nancy Nesser, PharmD. JD, Pharmacy Director

a) Consideration and vote to add Illaris®(canakinumab) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Dr. Nesser noted that the Drug Utilization Review Board recommends pharmacy prior authorization of ILARIS® (canakinumab) with the criteria detailed in **Item 8** of the board packet.

b) Consideration and vote to add Requip XL™(ropinirole) and Mirapex ER™(pramipexole) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Dr. Nesser stated that Drug Utilization Review Board recommends prior authorization for Requip XL™ (ropinirole) tablets and Mirapex ER™ (pramipexole) tablets to ensure appropriate utilization for the FDA approved indication for the treatment of signs and symptoms of Parkinson's disease and a justifiable reason why the immediate release products cannot be utilized. For details see **Item 8** of the board packet.

MOTION:	Vice Chairman moved for approval of Items 8a and 8b as presented. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp

c) Consideration and vote to add Lovaza® (Omega-3-Acid Ethyl Esters) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Dr. Nesser stated that the Drug Utilization Review Board recommends prior authorization of Lovaza® with criteria as detailed in **Item 8** of the board packet.

MOTION:	Member McFall moved for approval of Item 8c as presented. Member McVay seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp

ITEM 9 - DISCUSSION ITEM – PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLA. STATE. §307(B)(1),(4)&(7)

Howard Pallotta, Director of Legal Services

MOTION:	Member McFall moved for executive session. Member Bryant seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp

ITEM 10/NEW BUSINESS

NONE

ITEM 11/ADJOURNMENT

MOTION:	Member McFall moved for approval of the Adjournment. Vice Chairman Armstrong seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp

FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2010
Submitted to the CEO & Board
August 25, 2010

- Revenues for OHCA through June, accounting for receivables, were **$3,386,232,473** or **.2% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,354,175,253** or **.8% over** budget.
- The state dollar budget variance through June is **$8,760,850 positive.**
- The state dollar budget variance due to Medicare Part D Stimulus allocation is **$26,399,610 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(13.8)
Medicare Part D		26.4
Administration		4.1
Unbudgeted Carryover		3.4
Revenues:		
Unbudgeted State Appropriation		5.7
Taxes and Fees		4.1
Drug Rebate		1.4
Overpayments/Settlements		3.8
Total FY 10 Variance	**$**	**35.1**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
For the Fiscal Year Ended June 30, 2010

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 50,864,124	$ 50,864,124
Interest Earned	47,665	47,665
TOTAL REVENUES	**$ 50,911,789**	**$ 50,911,789**

EXPENDITURES	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 137,055,282	$ 48,243,459	
Eyeglasses and Dentures	299,113	105,288	
Personal Allowance Increase	3,488,700	1,228,022	
Coverage for DME and supplies	2,897,480	1,019,913	
Coverage of QMB's	1,032,756	363,530	
Part D Phase-In	2,659,731	2,659,731	
ICF/MR Rate Adjustment	4,817,736	1,695,843	
Acute/MR Adjustments	4,294,293	1,511,591	
NET - Soonerride	2,503,774	881,328	
Total Program Costs	**$ 159,048,863**	**$ 57,708,706**	**$ 57,708,706**
Administration			
OHCA Administration Costs	$ 518,696	$ 259,348	
DHS - 10 Regional Ombudsman	279,896	279,896	
OSDH-NF Inspectors	355,352	355,352	
Mike Fine, CPA	19,994	9,997	
Total Administration Costs	**$ 1,173,938**	**$ 904,593**	**$ 904,593**
Total Quality of Care Fee Costs	**$ 160,222,801**	**$ 58,613,299**	
TOTAL STATE SHARE OF COSTS			**$ 58,613,299**

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.

SoonerCare Programs

July 2010

Choice PCMH	JULY	
	2009	2010
Total Enrolled	415,982	447,717
American Indian Enrollment	11,926	14,196
Choice Enrollees (PCMH)	404,056	433,521

Traditional	JULY	
	2009	2010
Total Enrolled	215,702	224,030
SoonerCare Programs Total (Unduplicated)	651,777	697,277

Oklahoma Cares	JULY	
	2009	2010
Total Women Enrolled	2,701	2,221
SoonerCare Traditional	2,013	1,588
SoonerCare Choice	688	633
Total Women Ever-enrolled	20,430	23,899

SoonerPlan	JULY	
	2009	2010
Total Enrolled	20,093	25,530
Male Enrollees	569	837
Female Enrollees	19,524	24,693
Total Ever-enrolled	70,367	86,469

TEFRA	JULY	
	2009	2010
Total Children Enrolled	285	351
Male Enrollees	170	207
Female Enrollees	115	144
Total Ever-enrolled	368	475

Insure Oklahoma	JULY	
	2009	2010
IO Total Enrollees	23,532	31,994
IO Enrollees Males	10,300	13,832
IO Enrollees Females	13,232	18,162
ESI Enrollees	15,273	18,743
IP Enrollees	8,259	13,251

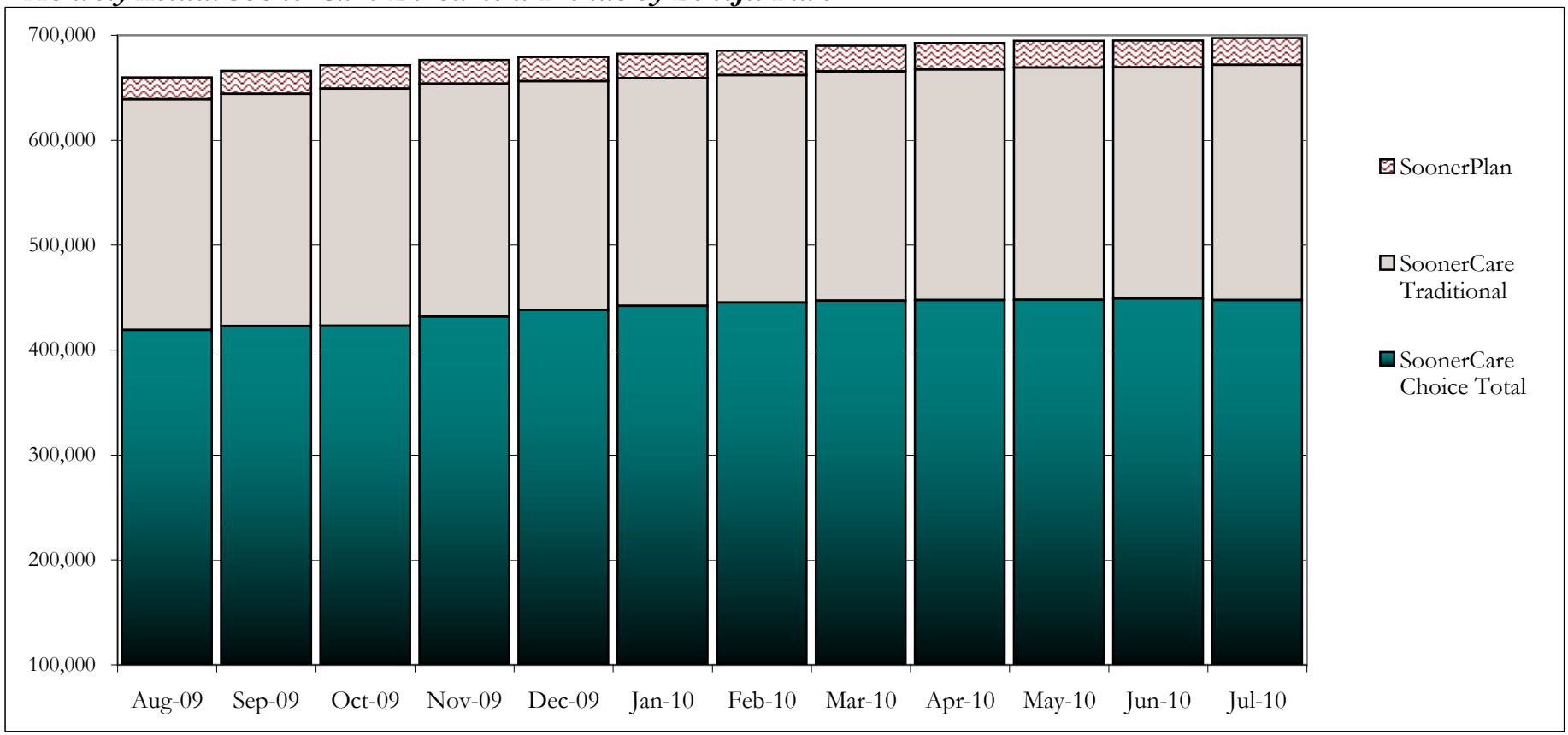
Program	FEBRUARY 2010	MARCH 2010	APRIL 2010	MAY 2010	JUNE 2010	JULY 2010
Choice PCMH	445,296	447,227	447,771	447,866	449,216	447,717
Traditional	216,542	218,449	219,772	221,397	220,283	224,030
Oklahoma Cares	2,396	2,368	2,369	2,347	2,243	2,221
TEFRA	326	323	329	337	345	351
SoonerPlan	23,607	24,379	25,257	25,635	25,652	25,530
Soon-to-be Sooners	2,993	3,051	3,034	3,069	3,061	3,065
SoonerCare Programs Total (Unduplicated)	**685,445**	**690,055**	**692,800**	**694,898**	**695,151**	**697,277**
Insure Oklahoma ESI	18,877	18,774	18,946	18,799	18,753	18,743
Insure Oklahoma IP	11,437	11,778	11,997	12,414	13,107	13,251
Insure Oklahoma Programs Total (Unduplicated)	**30,314**	**30,552**	**30,943**	**31,213**	**31,860**	**31,994**
Programs Total	**715,759**	**720,607**	**723,743**	**726,111**	**727,011**	**729,271**

August 20, 2010

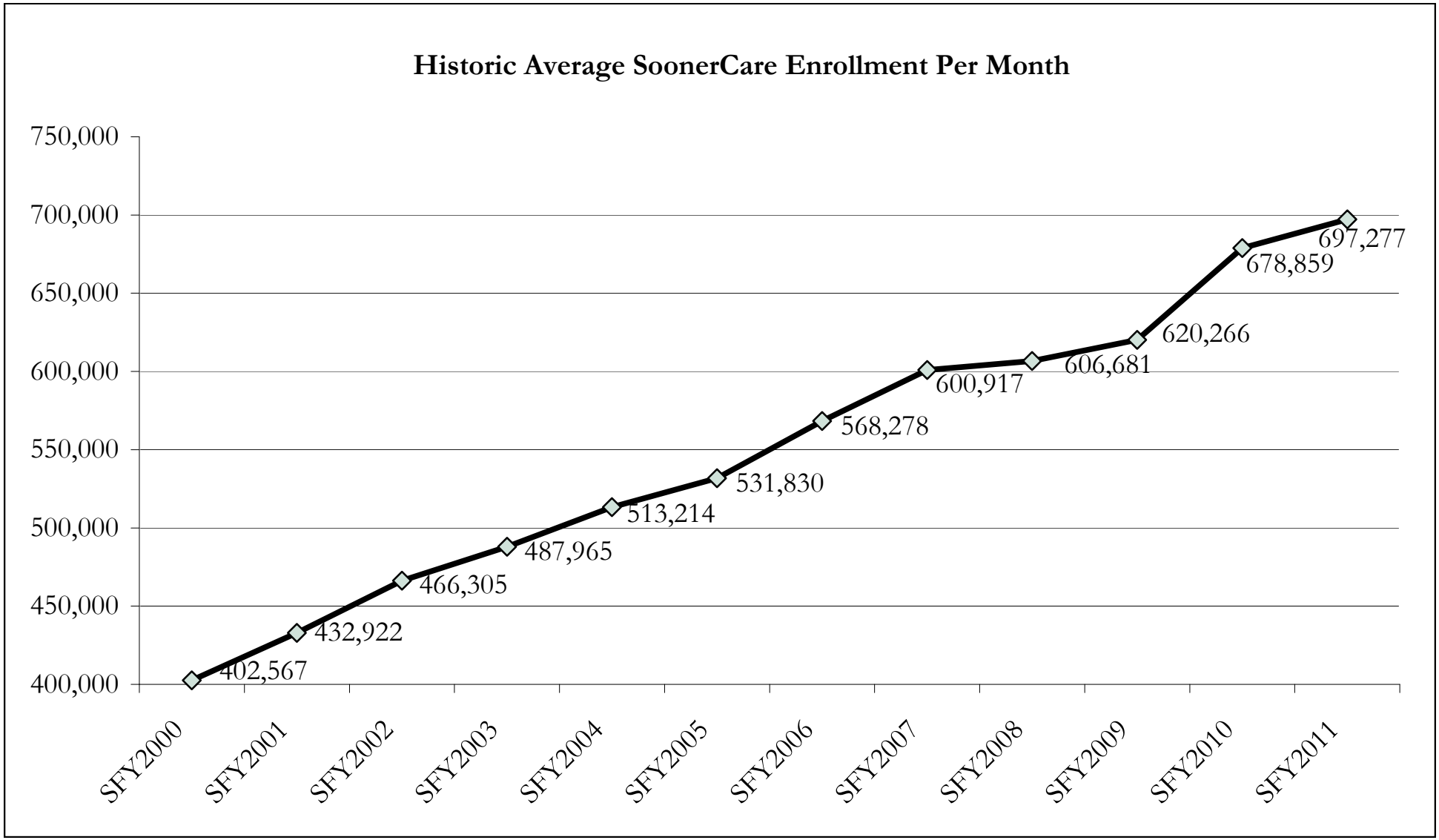
SOONERCARE ENROLLMENT PREVIOUS 12 MONTHS

	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice	407,312	410,597	410,763	419,311	424,913	428,704	431,677	433,447	433,771	433,655	434,969	433,521	4,669,119
IHS/Urban/Tribal	12,062	12,329	12,525	12,757	13,363	13,503	13,619	13,780	14,000	14,211	14,247	14,196	160,592
SoonerCare Choice Total	419,374	422,926	423,288	432,068	438,276	442,207	445,296	447,227	447,771	447,866	449,216	447,717	5,263,232
SoonerCare Traditional	219,633	221,392	225,914	221,734	217,945	216,989	216,542	218,449	219,772	221,397	220,283	224,030	
SoonerPlan	20,937	21,724	22,498	22,788	23,073	23,420	23,607	24,379	25,257	25,635	25,652	25,530	284,500
TOTAL ENROLLEES	659,944	666,042	671,700	676,590	679,294	682,616	685,445	690,055	692,800	694,898	695,151	697,277	8,191,812
Average Monthly Enrollment													*681,321*

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months


Historic Average SoonerCare Enrollment Per Month
750,000
700,000
650,000
600,000
550,000
500,000
450,000
400,000
402,567
432,922
466,305
487,965
513,214
531,830
568,278
600,917
606,681
620,266
678,859
697,277
SFY2000
SFY2001
SFY2002
SFY2003
SFY2004
SFY2005
SFY2006
SFY2007
SFY2008
SFY2009
SFY2010
SFY2011

SoonerCare Fast Facts

July 2010

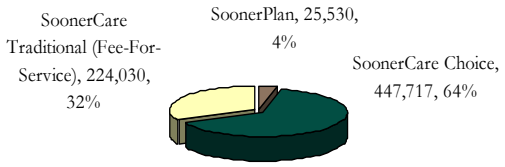
TOTAL ENROLLMENT —
OKLAHOMA SOONERCARE (MEDICAID)

Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	19,065	2.73%
Aged/Blind/Disabled	Adult	126,289	18.11%
Children/Parents	Child	458,240	65.72%
Children/Parents	Adult	47,212	6.77%
Other	Child	76	0.01%
Other	Adult	18,293	2.62%
Oklahoma Cares (Breast & Cervical Cancer)		2,221	0.32%
SoonerPlan (Family Planning)		25,530	3.66%
TEFRA		351	0.05%
Total Enrollment	**697,277**	Adults	216,071 31%
		Children	481,206 69%

OTHER Group includes—DDSD State-PKU-Q1-Q2-Refugee--SLMB-Soon to be Sooners (STBS) and TB patients. Child custody was moved to Children/Parents effective April 2010.
For more information go to www.okhca.org under Individuals then to Programs. Insure Oklahoma members are NOT included in the figures above.

Note that all subsequent figures are groups within the above total enrollment numbers (except Insure Oklahoma). SoonerPlan (Family Planning) members are not entitled to the full scope of benefits only family planning services are covered.

Delivery System Breakdown of Total Enrollment



Other Enrollment Facts

Unduplicated enrollees State Fiscal Year-to-Date (July through report month including Insure Oklahoma) — **729,271**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — **15,597**

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — **101,606**

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage—O-EPIC) is a program to assist qualifying small business owners, employees & their spouses (Employer Sponsored Insurance—**ESI**) and some individual Oklahomans (Individual Plan—**IP**) with health insurance premiums. www.insureoklahoma.org

Small Businesses Enrolled in ESI	Employees w/ ESI	Individual Plan (IP) Members
5,460	**18,743**	**13,251**

New Enrollees

Oklahoma SoonerCare members that have not been enrolled in the past 6 months.

Adults	6,566
Children	8,686
Total	**15,252**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	60,393	20,341	12%	2,834
Asian or Pacific Islander	7,091	2,907	1%	699
Black or African American	69,615	30,264	14%	2,431
Caucasian	328,577	159,874	70%	20,025
Multiple Races	15,530	2,685	3%	766
Hispanic Ethnicity	76,684	11,156	13%	6,114

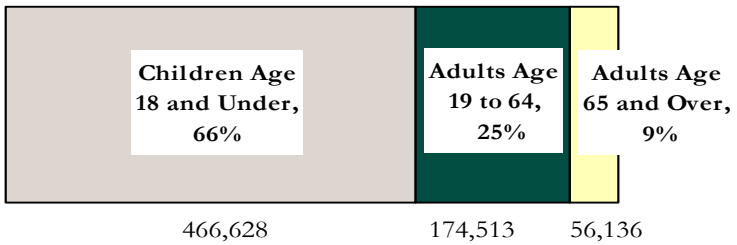
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

CHIP Breakdown of Total Enrollment

Members qualifying for SoonerCare (Medicaid) eligibility under the CHIP program are under age 19 and have income between the maximum for standard eligibility and the expanded 185% of Federal Poverty Level (FPL) income guidelines.

Age Breakdown	% of FPL	CHIP Enrollees
PRENATAL		3,065
INFANT	150% to 185%	1,488
01-05	133% to 185%	11,737
06-12	100% to 185%	32,953
13-18	100% to 185%	20,746
Total		**69,989**

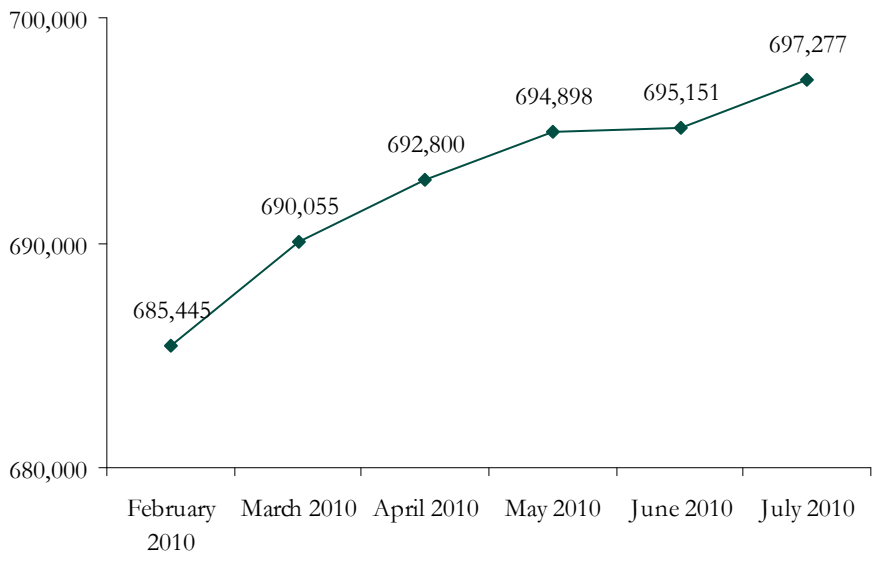
Age Breakdown of Total Enrollment



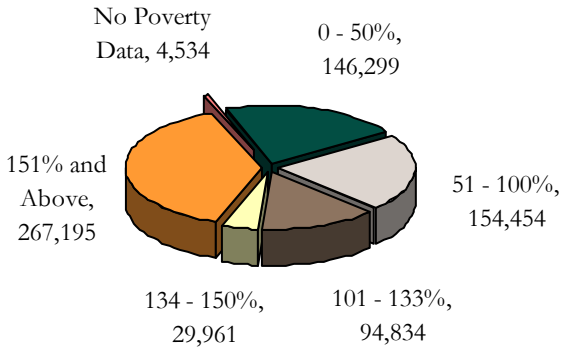
Data was compiled on 8/10/2010. Numbers frequently change due to certifications occurring after the data is extracted and other factors. This report is based on data within the system prior to 8/10/2010. A majority of the data is a "point in time" representation of the specific report month and is not cumulative. Unless stated otherwise, CHILD is defined as an individual under the age of 21.

SoonerCare Fast Facts
July 2010

Total Enrollment Trend



Percent of Federal Poverty Level Totals



The "No Poverty Data" group consists of members with no poverty data and members enrolled with an aid category of U- DDSD State, R2 - OJA not Incarcerated, or R4 - OJA Incarcerated. These aid categories do not require poverty data or do not use the poverty data.

July 15, 2010

OHCA Contact: Jo Kilgore, Public Information Manager, (405) 522-7474.

Garth Splinter Returns to OHCA as State Medicaid Director

OKLAHOMA CITY – Garth L. Splinter, M.D., is Oklahoma's new Medicaid director, Oklahoma Health Care Authority CEO Mike Fogarty announced.

Splinter is a familiar face at the agency, where he was administrator from 1994-99, and in Oklahoma's medical community. He more recently served as an associate professor and division head for the Primary Care Health Policy Division in the Department of Family and Preventive Medicine at the University of Oklahoma's College of Medicine. For four years, he also was chief medical officer for the University Hospitals Trust.

"I've been away from OHCA for 11 years, and I see a considerable difference," Splinter said. "Its budget is three or four times larger, and it has twice as many people. However, the focus on excellence is unchanged."

He anticipates that some of the major tasks awaiting him as state Medicaid director are assisting with the federal health reform's impact on Oklahoma and the effects of the ongoing state budget shortfall on OHCA.

Splinter's diverse educational and professional background will give him a unique perspective when dealing with complexities facing the agency. He earned a bachelor's degree in industrial engineering from OU and a master's in business administration from Harvard before returning to OU for his M.D.

He succeeds Lynn Mitchell, M.D., who has moved to the Oklahoma State Department of Health to serve as deputy commissioner of prevention and preparedness services and chief medical officer.

Oklahoma Health Care Authority

Provider Fast Facts

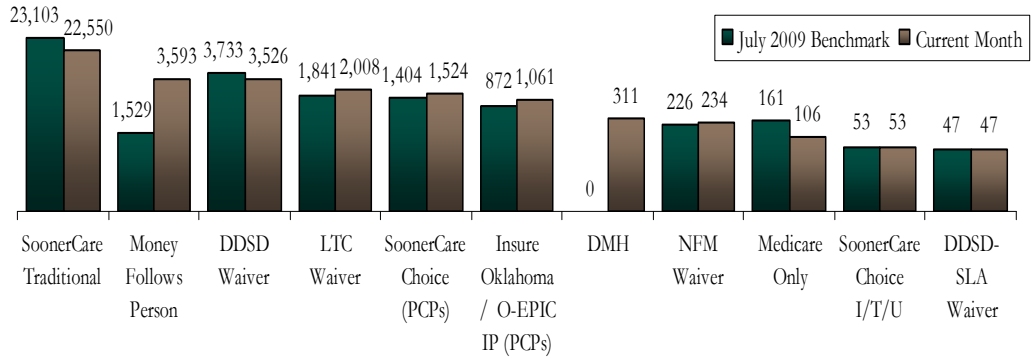
July 2010

Total Unduplicated Provider Count

28,860

All subsequent provider counts were derived from the total unduplicated provider count. Some providers may be counted in multiple programs.

Total Unduplicated Provider Count by Program



A group provider is a corporation that houses multiple individual providers. In order to provide a more accurate count, the group's individual providers were counted instead of the group provider.

Total Unduplicated Newly Enrolled Provider Count

483

Total unduplicated newly enrolled provider count was determined by the number of newly unduplicated provider IDs added during the month of this report.

Primary Care Provider (PCP) Capacities

SoonerCare Program Description	Total Capacity	% of Capacity Used
SoonerCare Choice	1,029,398	42.27%
SoonerCare Choice I/T/U	118,150	12.26%
Insure Oklahoma/O-EPIC IP	337,532	3.88%

Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit.

Acronyms

DDSD - Developmental Disabilities Services Division

DDSD-SLA - Developmental Disabilities Services Division-Supported Living Arrangement

DME - Durable Medical Equipment

DMH - Department of Mental Health

I/T/U - Indian Health Service/Tribal/Urban Indian

LTC - Long-Term Care

NET - Non-Emergency Transportation

NFM - Non-Federal Medical

NPI - National Provider Identifier

O-EPIC IP - Oklahoma Employer/Employee Partnership for Insurance Coverage Individual Plan

PCMH - Patient-Centered Medical Home

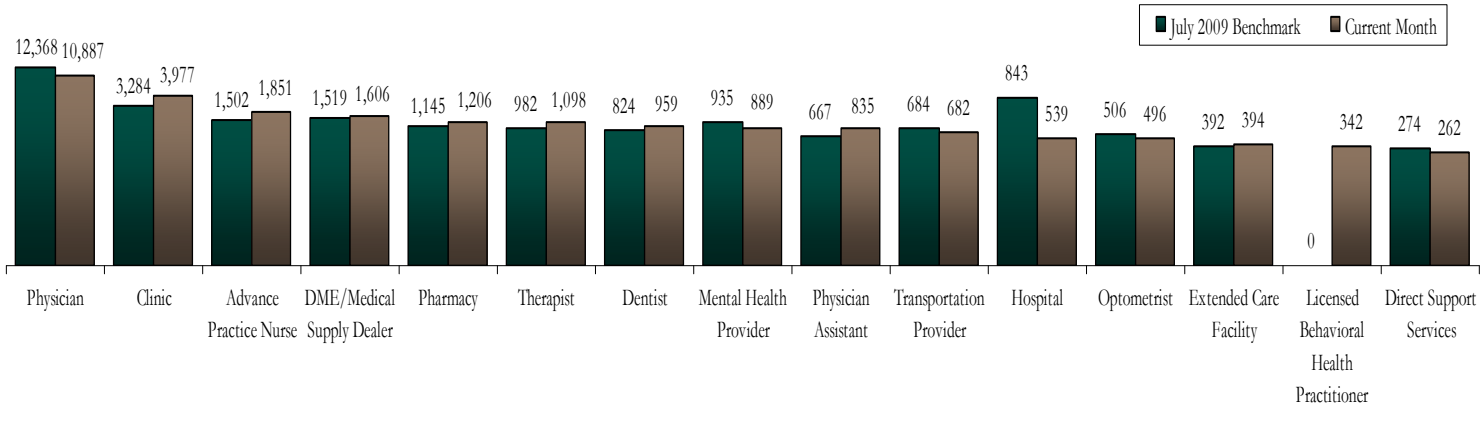
PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	519
Tier 2	215
Tier 3	45

These counts were computed using a different method than indicated elsewhere on the report and are not comparable to any other figures.

Top 15 Provider Types

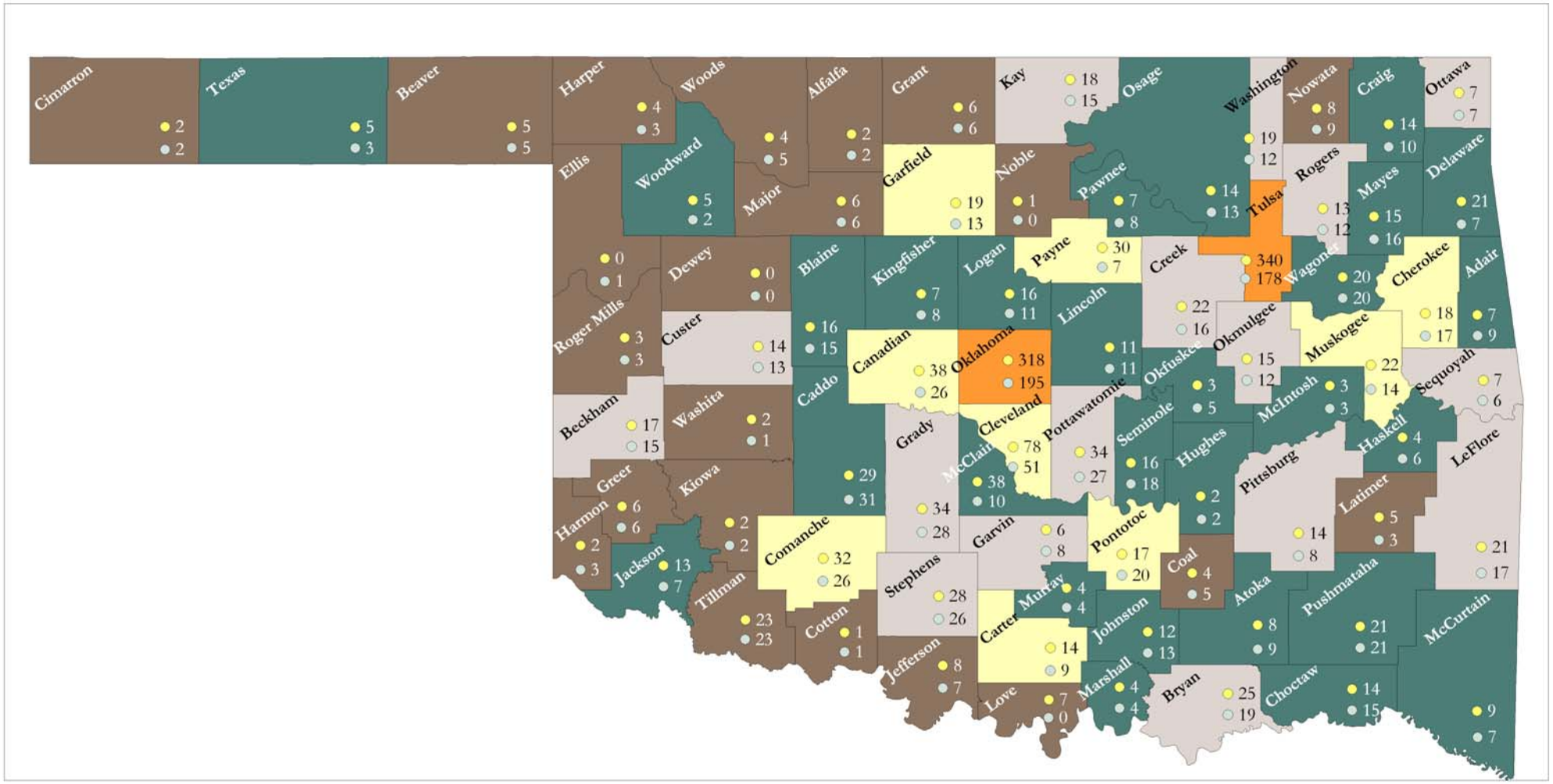


The top 15 provider types consists of the 15 provider types with the highest number of contracted providers.

Provider Fast Facts

July 2010

oklahoma health care authority



Total Provider Count

- 4,000 to 5,520 (2)
- 300 to 1,100 (9)
- 150 to 300 (16)
- 50 to 150 (28)
- 0 to 50 (22)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

08/11/2010

Insure Oklahoma
Fast Facts
August 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

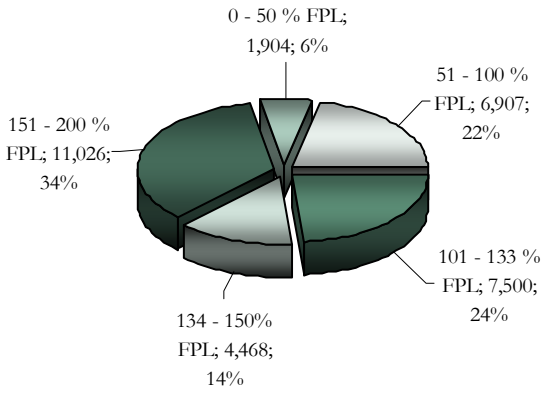
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent). The Individual Plan (IP) allows people who can't access the benefits through their employer, including those who are self-employed or may be temporarily unemployed, to buy health insurance directly through the state. Find out more information by visiting **www.insureoklahoma.org** or by calling 1-888-365-3742.

Insure Oklahoma Total Enrollment

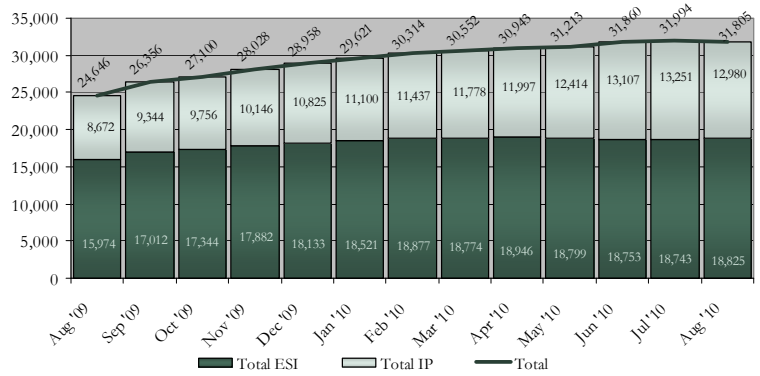
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	15,549	48.89%
Employer Sponsored Insurance (ESI)	Spouse	3,109	9.78%
Individual Plan (IP)	Employee	9,791	30.78%
Individual Plan (IP)	Spouse	2,970	9.34%
Student (ESI)	---	67	0.21%
Student (IP)	---	219	0.69%
Dependent (ESI)	---	100	0.31%
Dependent (IP)	---	0	0.00%
Businesses	---	5,499	---
Carriers / HealthPlans	---	21 / 477	---
Primary Care Physician	---	1,152	---

Total Enrollment	**31,805**	ESI	18,825	59%
		IP	12,980	41%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment



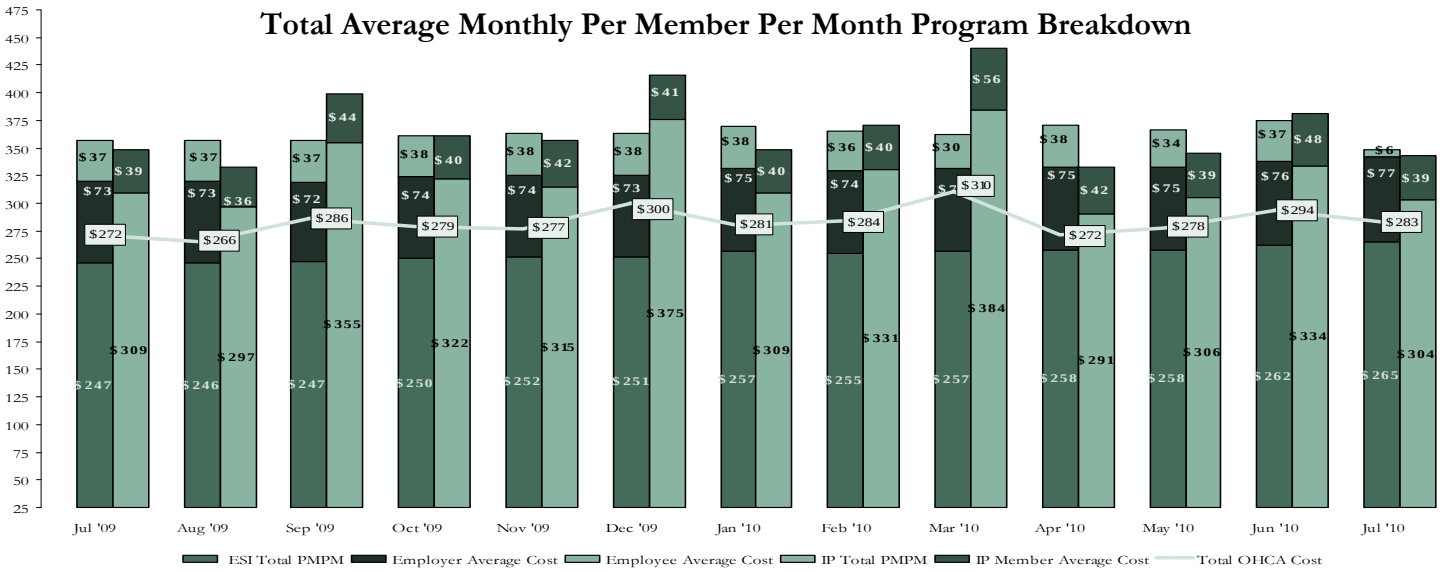
Currently Enrolled		Up from Previous Year
Businesses	5,499	8%
ESI Enrollees	18,825	18%
IP Enrollees	12,980	50%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	37,076
Call Center - Calls Answered	14,844

Call Center count now includes OHCA calls.
Unable to produce Call Center Counts for April.

Total Average Monthly Per Member Per Month Program Breakdown



All the state share of the Insure Oklahoma program costs are budgeted from the state's tobacco tax revenues. (All financial information is previous month activity.)

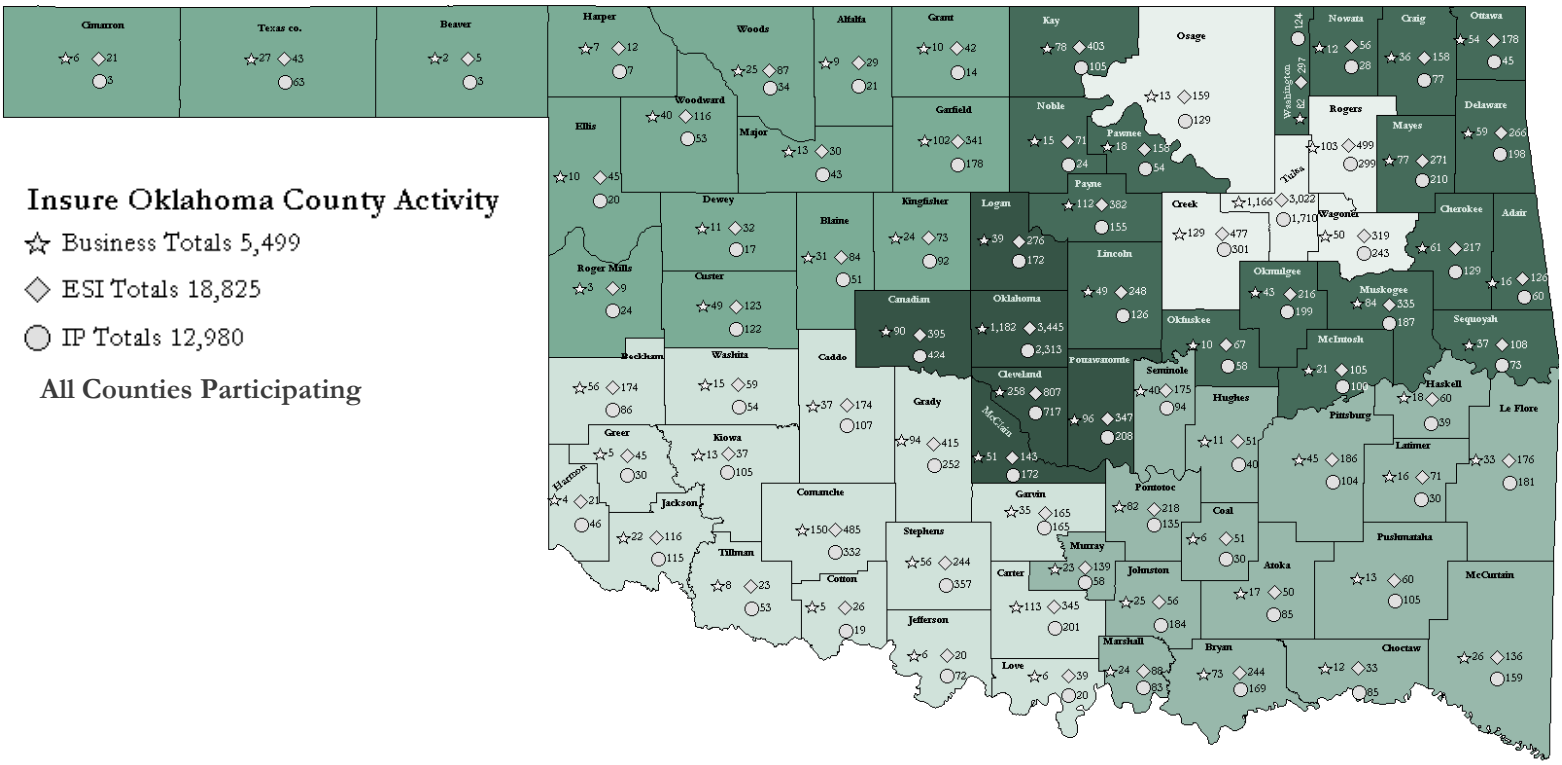
Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

8/2/2010

Insure Oklahoma
Fast Facts
August 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

November 2005	Oklahoma implemented Insure Oklahoma Employer Sponsored Insurance (ESI), the premium assistance for health insurance coverage targeting some 50,000 low-wage working adults in Oklahoma.
January 2007	Insure Oklahoma implements the Individual Plan (IP) to assist sole proprieetors (self employed), certain unemployed individuals, and working individuals who do not have access to small group health coverage.
November 2007	Increased Insure Oklahoma ESI qualifying income guidelines from 185 to 200 percent of the federal poverty level.
	ESI available to businesses with 25 to 50 employees.
March 2009	Expanded IP to offer coverage for full-time Oklahoma college students within qualifying income guidelines age 19 through 22.
	ESI available to businesses with 50 to 99 employees.



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8/2/2010

Employer Sponsored Insurance (ESI)

Fast Facts

August 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

The Insure Oklahoma Employer Sponsored Insurance program is designed to assist small business owners, employees and their spouses with health insurance premiums. Find out more information by visiting **www.insureoklahoma.org**.

Employer Sponsored Insurance

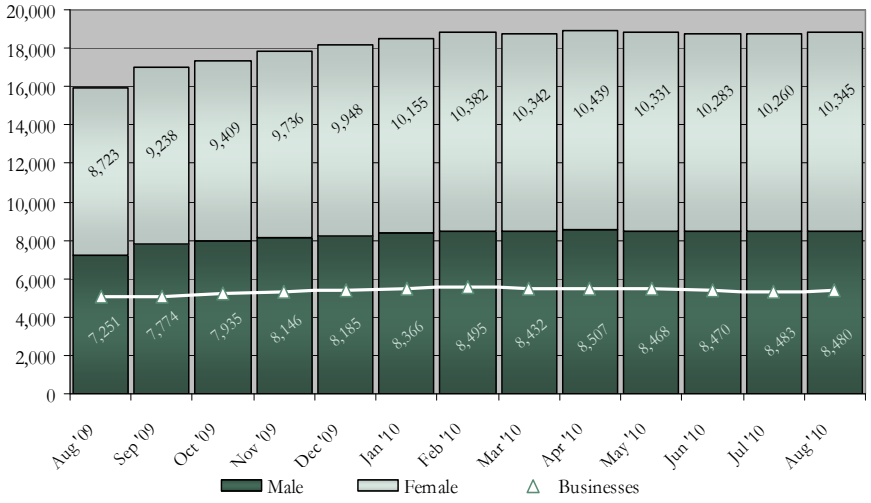
	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	7,618	7,931	**15,549**	357	321	**678**	909	784	**1,693**
Spouse	781	2,328	**3,109**	27	97	**124**	83	241	**324**
Student	34	33	**67**	0	0	**0**	5	1	**6**
Dependent	47	53	**100**	10	16	**26**	47	53	**100**
Total	8,480	10,345	**18,825**	394	434	**828**	1,044	1,079	**2,123**

*Dependents effective 8/1/2010 whether new or existing Household.

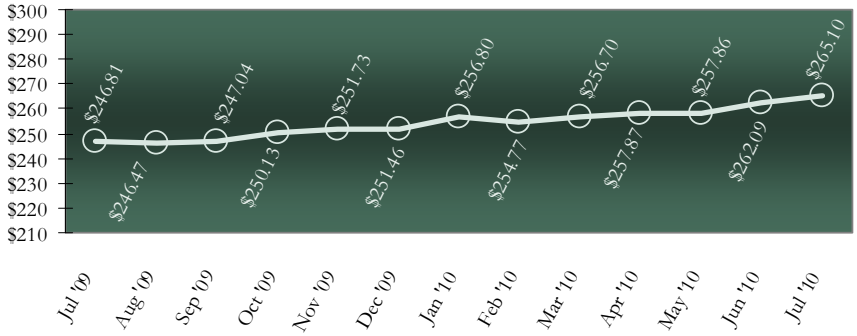
Business Activity with Employee Participation Counts				
	0 to 25	26 to 50	51 to 100	Total
Current	4,645	482	257	**5,384**
New	101	10	4	**115**
Total	**4,746**	**492**	**261**	**5,499**

Some approved businesses may not have approved employees.

Member and Employer Monthly Enrollment

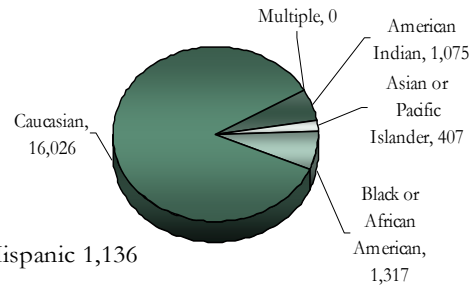


Average OHCA Premium Assistance Payments



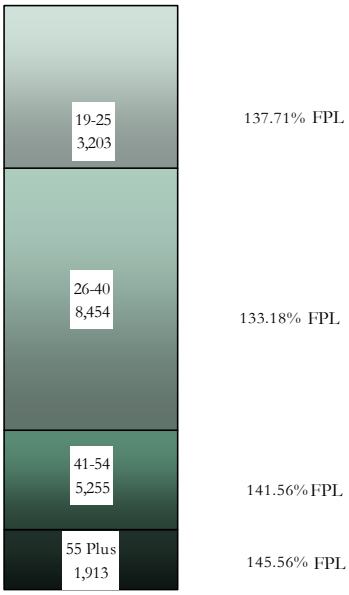
Effective February 2007 OHCA Per Member Per Month reporting will be of the previous month due to semi-monthly payments verses monthly payments.

Race Breakdown of ESI Members



Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Age Breakdown with Average Federal Poverty Level of ESI Members



Federal Poverty Level is used to determine income qualification.

Insure Oklahoma/OEPIC ESI by Region			
	Employers	Employee/ Spouse	Participating Counties
Region 1	625	2,388	16 of 16
Region 2	369	1,092	16 of 16
Region 3	1,716	5,413	6 of 6
Region 4	1,461	4,476	5 of 5
Region 5	864	3,662	18 of 18
Region 6	464	1,794	16 of 16
Total	**5,499**	**18,825**	**77 of 77**

Regions identified on Insure Oklahoma/OEPIC Region map on next page.

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

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8/3/2010

Individual Plan (IP)
Fast Facts

August 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

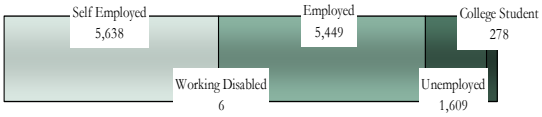
The Insure Oklahoma Individual Plan program is designed to provide Oklahoma individuals with health insurance for themselves and their spouse if needed. It is available to Oklahomans who are not qualified for an employer-sponsored health plan and work for an Oklahoma small business with 99 or fewer full time employees; temporarily unemployed adults who are eligible to receive unemployment benefits through the Oklahoman Employment Security Commission; or working adults with a disability who work for any size employer and have a "ticket to work". Find out more information by visiting **www.insureoklahoma.org**.

Individual Plan (IP)

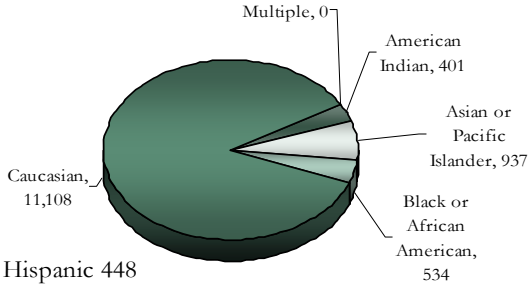
	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	4,485	5,306	**9,791**	112	162	**274**	335	336	**671**
Spouse	672	2,298	**2,970**	22	53	**75**	60	174	**234**
Student	91	128	**219**	2	2	**4**	9	6	**15**
Dependent	0	0	**0**	0	0	**0**	0	0	**0**
Total	5,248	7,732	**12,980**	136	217	**353**	404	516	**920**

*Dependents effective 9/1/2010 whether new or existing Household.

IP Application Type Breakdown



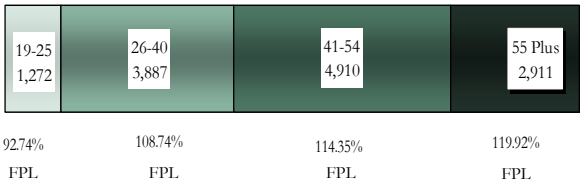
Race Breakdown of IP Members



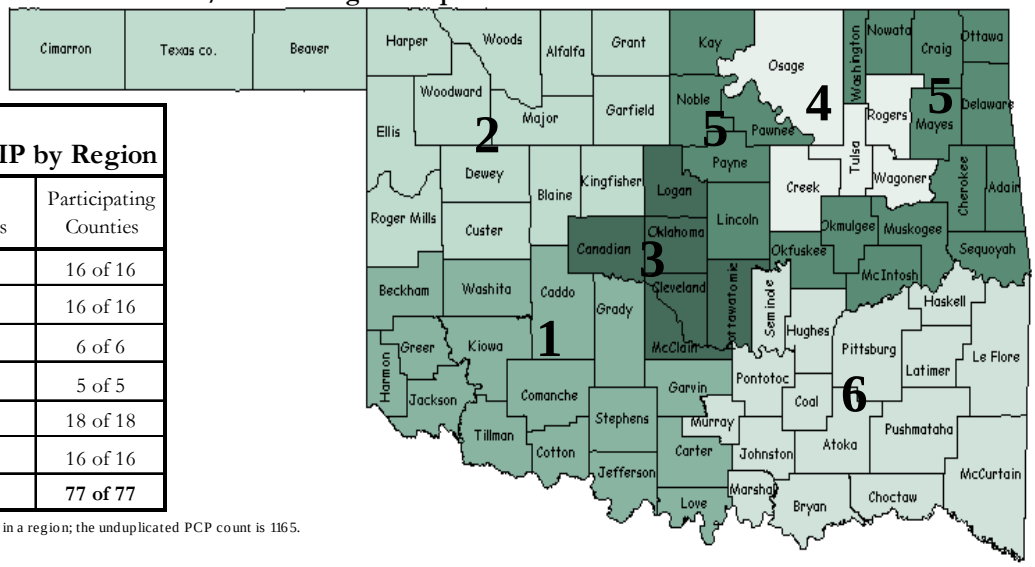
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	13,995
IP Members Since Program Inception March 2007	21,756
Miscellaneous	
Average IP Member Premium	$56.49
Average Federal Poverty Level of IP Members	111.80%
Federal Poverty Level is used to determine income qualification.	

IP Age Breakdown with Average Federal Poverty Level for each group.



Insure Oklahoma/OEPIC Region Map



Insure Oklahoma/OEPIC IP by Region

	PCP	Participating Counties	Members	Participating Counties
Region 1	166	16 of 16	2,014	16 of 16
Region 2	83	15 of 16	745	16 of 16
Region 3	346	6 of 6	4,006	6 of 6
Region 4	240	5 of 5	2,682	5 of 5
Region 5	163	17 of 18	1,952	18 of 18
Region 6	154	16 of 16	1,581	16 of 16
Total	**1,152**	**75 of 77**	**12,980**	**77 of 77**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 1165.

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8/3/2010

6.b-1 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 75. Federally Qualified Health Centers
OAC 317:30-5-660. [AMENDED]
OAC 317:30-5-660.1. [AMENDED]
OAC 317:30-5-660.3. through 317:30-5-660.5. [AMENDED]
OAC 317:30-5-661.1 [AMENDED]
OAC 317:30-5-661.4 [AMENDED]
OAC 317:30-5-661.5 [AMENDED]
OAC 317:30-5-661.7 [AMENDED]
OAC 317:30-5-664.3 [AMENDED]
OAC 317:30-5-664.5 [AMENDED]
OAC 317:30-5-664.7 [AMENDED]
OAC 317:30-5-664.10 [AMENDED]
OAC 317:30-5-664.11 [REVOKED]
(Reference APA WF # 10-04)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to amend policy to clarify reimbursement for certain Licensed Behavioral Health Professionals in Federally Qualified Health Centers (FQHC). Additionally, revisions are made to reflect contracting and reimbursement requirements for covered services in FQHC's and school settings. Policy revisions are needed to make certain LBHP's who provide behavioral health services in FQHC's are reimbursed appropriately. Revisions are also needed to identify behavioral health services that are permissible in FQHC's and school settings. These revisions ensure that the reimbursement rates for services rendered in FQHC's comply with cost based reimbursement accounting principles thereby eliminating payment errors and guarding the Agency's Federal Financial Participation from being at risk.

ANALYSIS: Rules are being revised to clarify reimbursement methods for providers in FQHC's and their relationship to the Prospective Payment System (PPS) rate. Currently, rules are not clear as to which providers would be reimbursed the PPS rate or the Fee-for-service rate for services provided. Additionally, rules are revised to clarify requirements for FQHC contracting and behavioral health services provided in school settings.

BUDGET IMPACT: Agency staff has determined that the rule revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on July 15, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rules to clarify reimbursement methods for providers in FQHC's and their relationship to the Prospective Payment System (PPS) rate as well as to clarify requirements for FQHC contracting and behavioral health services provided in school settings.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660. Eligible providers
(a) Federally Qualified Health Centers (FQHC) are entities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. The facilities in this Part are hereafter referred to as "Health Centers" or "Centers".
(b) For purposes of providing covered services under ~~Medicaid~~ SoonerCare, Health Centers may qualify by one of the following methods:
(1) The entity receives a grant under Section 330 of the Public Health Service (PHS) Act (Public Law 104-229), receives funding from such grants under a contract with the recipient of such a grant and includes an outpatient health program or entity operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638);
(2) The Health Resources and Services Administration (HRSA) within the PHS recommends, and the Centers for Medicare and Medicaid Services (CMS) determines that, the entity meets the requirements for receiving such a grant and is designated a FQHC look-alike; or
(3) The Secretary of Health and Human Services determines that an entity may, for good cause, qualify through waiver of requirements. Such a waiver cannot exceed a period of two years.
(c) Any entity seeking to qualify as a FQHC should contact the U.S. Public Health Service.

317:30-5-660.1. Health Center multiple sites contracting
(a) Health Centers may contract as SoonerCare Traditional providers and as a PCP/CM under SoonerCare Choice (Refer to OAC 317:25-7-5).
(b) Health Centers are required to submit a list of all entities affiliated or owned by the Center including any programs that do not have Health Center status, along with all OHCA provider numbers.
(c) Payment for FQHC services is based on a Prospective Payment System (PPS). (Refer to OAC 317:30-5-664.10) In order to be eligible for reimbursement under this method for covered services, in traditional primary care settings, each site must submit an approval copy of the Health Resource and Service Administration (HRSA) Notice of Grant Award Authorization for Public Health Services Funds under Section 330, (or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC)and a copy of the Medicare certification number, at the time of enrollment.

317:30-5-660.3. Health Center enrollment requirements for ~~other~~ specialty behavioral health services
(a) For the provision of behavioral health related case management services, Health Centers must meet the requirements found at ~~OAC 317:30-5-585 through 317:30-5-589 and~~ OAC 317:30-5-595 through 317:30-5-599.

(b) For the provision of psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC 317:30-5-240 through 30-5-249.
(c) Health Centers which provide substance abuse treatment services must also ~~have a contract~~ be certified by ~~with~~ the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

317:30-5-660.4. Health Center enrollment requirements for ~~school-based~~ health services in a school setting

(a) For the provision of ~~school-based health~~ physical and behavioral health services provided in accordance with the Individuals with Disabilities Education Act (IDEA) and pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) are the responsibility of the school district. ~~(not a health care delivery site),~~ Health Centers must ~~be contracted~~ contract with ~~a qualified school provider~~ the school district and invoice the school district for services rendered. Refer to OAC 317:30-5-1020 through 30-5-1027. Reimbursement is made directly to the school.
(b) Payment may be made for FQHC services to Health Centers that have a health care delivery site in a school setting (i.e., the school has no responsibility under IDEA/~~no contract with OHCA~~ and a parental authorization must be on file) and that has a HRSA Grant Award Authorization or "look alike" designation.

317:30-5-660.5. Health Center service definitions

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

"Core Services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.

"Core Practitioners" means a physician, physician assistant, advanced practice nurse, certified nurse midwife, licensed psychologist, licensed clinical social worker and visiting nurse.

"Encounter or Visit" means a face-to-face contact between a ~~health care professional~~ core practitioner and an eligible SoonerCare member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the patient's medical record.

"Licensed ~~Mental~~ Behavioral Health Professional ~~(MHP)~~ (LBHP)" means licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).

"Non-Core Licensed Behavioral Health Professionals" means services provided by licensed martial and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).

"Other ambulatory services" means other health services covered under the State plan other than core services.

"Physician" means:

(A) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;
(B) within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, or a doctor of podiatry;
(C) a resident as defined in OAC 317:25-7-5(4) who meet the requirements for payment under SoonerCare;

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the State plan.

317:30-5-661.1. Health Center core services

Health Center "core" services include:

(1) Physicians' services and services and supplies incident to a physician's services;

(2) Services of advanced practice nurse (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(3) Services and supplies incident to the services of APNs, nurse midwives, and PAs;

(4) Visiting nurse services to the homebound;

(5) ~~Mental health professional services~~ Services of Licensed Psychologists and Licensed Clinical Social Workers (LCSWs) and services and supplies incident to the services of ~~MHPs~~ licensed psychologists and LCSWs;

(6) Preventive primary care services;

(7) Preventive primary dental services.

317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings

(a) Medically necessary behavioral health services that are primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. ~~Services provided by a Health Center (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by other behavioral health providers.~~ Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2, 317:30-5-280 and 317:30-5-595.

(1) Behavioral Health ~~Services~~ services include:

~~(1)~~ (A) Assessment/Evaluation~~/Testing~~;

~~(2) Alcohol and/or Substance Abuse Services Assessment and Treatment plan development;~~

~~(3)~~ (B) Crisis Intervention Services;

~~(4) Medication Training and Support~~

~~(5)~~ (C) Individual/Interactive Psychotherapy;

~~(6)~~ (D) Group Psychotherapy; ~~and~~

~~(7)~~ (E) Family Psychotherapy~~.~~ ;

(F) Psychological Testing; and

(G) Case Management (as an integral component of services 1-6 above).

(2) Non-Core LBHP behavioral health services must meet the same requirements as services provided by outpatient behavioral health providers in other settings.

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified ~~mental~~ behavioral health ~~and/or substance abuse~~ disorder(s). A minimum of a 45 to 50 minute one-on-one standard clinical session must be completed by a core provider ~~Health Center~~ in order to bill ~~an~~ the PPS encounter rate for the session.

~~(c) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.~~

(c) Non-core LBHPs are limited to a total of 8 sessions per member per month and 8 units of testing per member per year.

(d) **Behavioral health programs in school settings.** School-based and family - directed services for children are covered as follows:

(1) Behavioral health programs in school must:

(A) Be under direction of a LBHP;

(B) Be implemented in collaboration with relevant community stakeholders;

(C) Be uniquely designed to fit local community needs;

(D) Be integrated as part of the larger educational mission of the school;

(E) Develop adequate procedures to identify, assess, and enroll students in need of services;

(F) Develop adequate procedures for outreach, engagement, training, and supporting the efforts of parents and family members;

(G) Have informed consent, confidentially of participation and security of records;

(H) Have staff available 24 hours per day.

(2) All services must be developed in accordance with assessment and treatment plan by a LBHP.

(3) **Reimbursement for behavioral health programs in school settings.** Services provided by core providers in the school-based setting are reimbursed at the PPS encounter rate (see OAC 317:30-5-664.3) if enrollment requirements found in OAC 317:30-5-660.4 are met. Services provided by Non-Core LBHP's in the school-based setting are reimbursed according to the SoonerCare fee-for-service fee schedule and the limits set forth in 317:30-5-661.4(c) apply. If the enrollment requirements found in 317:30-5-660.4 are not met, all LBHP's (core and non-core) must follow the rules found at OAC 317:30-5-280 through 317:30-5-283. Individual practitioners must meet the minimum provider qualifications for each service found at OAC 317:30-5-240.3, 317:30-5-595 and 317:30-5-280. Refer to OAC 317:30-5-241 for a description of services:

(A) Assessments and Treatment Plan development;

(B) Individual, family and group therapy and counseling;

(C) Crisis intervention;

(D) Case management; and

(E) Psychological testing for behavioral health related issues (academic is non-allowable and must be conducted by the school system).

(4) **Day Treatment programs provided by Health Centers.** Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC 317:30-5-240.2(7)

(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

317:30-5-661.5. Health Center preventive primary care services

(a) Preventive primary care services are those health services that:

(1) a Health Center is required to provide as preventive primary health services under section 330 of the Public Health Service Act;

(2) are furnished by or under the direct supervision of an APN, PA, CNMW, specialized advanced practice nurse practitioner, ~~MHP~~ licensed psychologist, LCSW , or a physician;

(3) are furnished by a member of the Health Center's health care staff who is an employee of the Center or provides services under arrangements with the Center; and

(4) includes only drugs and biologicals that cannot be self-administered.

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

(1) medical social services;
(2) nutritional assessment and referral;
(3) preventive health education;
(4) children's eye and ear examinations;
(5) prenatal and post-partum care;
(6) perinatal services;
(7) well child care, including periodic screening (refer to OAC 317:30-3-65);
(8) immunizations, including tetanus-diphtheria booster and influenza vaccine;
(9) voluntary family planning services;
(10) taking patient history;
(11) blood pressure measurement;
(12) weight;
(13) physical examination targeted to risk;
(14) visual acuity screening;
(15) hearing screening;
(16) cholesterol screening;
(17) stool testing for occult blood;
(18) dipstick urinalysis;
(19) risk assessment and initial counseling regarding risks;
(20) tuberculosis testing for high risk patients;
(21) clinical breast exam;
(22) referral for mammography;
(23) thyroid function test; and
(24) dental services (specified procedure codes).

317:30-5-661.7. ~~Off-site~~ Allowable Places of services

(a) ~~Off-site~~ Services ~~means services~~ provided to members within the four walls of the ~~at a location other than the Center. Off-site services are considered Health Center services if the physician's or other practitioner's agreement requires that he or she seek reimbursement from the Health Center.~~ Health Center and approved Health Center satellites including mobile health clinics operated by the Center are allowable for reimbursement under the PPS. ~~Off-site services include services provided at mobile health clinics operated by the Center. Services provided by Centers in school settings (i.e., the school has no responsibility/no contract with OHCA and a parental authorization must be on file) are considered off-site services. (b) Medically necessary Health Center services provided off-site or outside of the Health Center setting are compensable when billed by the Center. The Health Center must have a written contract with the physician and other Center core practitioners that specify that Center services provided off site will be billed to Medicaid and, how such providers will be compensated. It is expected that services provided in off-site settings should be, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.~~

~~(c) In order to support the member's access to behavioral health services, these services may take place in settings away from the Center. Off-site behavioral health services must take place in a confidential setting.~~

(b) Off-site services provided by employed practitioners of the Health Center to patients temporarily homebound or in any skilled nursing facility because of a medical condition that prevents the patient from going to the Health Center for health care are also allowable for reimbursement under the PPS encounter rate if the service would be reimbursed the PPS at the Center. It

is expected that services provided in off-site settings should be, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

317:30-5-664.3. Health Center encounters

(a) Health Center encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. ~~These services include other health (ambulatory) services included in the State Plan~~.

(1) Only encounters provided by core practitioners within the scope of their licensure for integrated primary and behavioral health care services listed in 317:30-5-661.4 trigger a PPS encounter rate.

(2) Behavioral health services provided by Non-Core LBHPs within the scope of their licensure for services listed in 317:30-5-661.4 are reimbursed according to the SoonerCare fee-for-service fee schedule.

(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the member's medical record.

(c) For information about multiple encounters, refer to OAC 317:30-5-664.4.

(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) medical;

(2) diagnostic;

(3) ~~addiction,~~ dental, medical and ~~mental~~ behavioral health screenings;

(4) vision;

(5) physical therapy;

(6) occupational therapy;

(7) podiatry;

(8) ~~mental~~ behavioral health;

~~(9) alcohol and drug~~;

~~(10)~~ (9) speech;

~~(11)~~ (10) hearing;

~~(12)~~ (11) medically necessary Health Center encounters with a RN or LPN and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3);

~~(13)~~ (12) any other medically necessary health services provided by non-core practitioners (i.e. optometrists and podiatrists) ~~covered by OHCA~~ are also reimbursable as permitted within the Health Center's scope of services when Medicare would cover as an all-inclusive encounter ~~and allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules~~.

317:30-5-664.5. Health Center encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to OAC 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently CLIA certified and enrolled laboratory.

(2) Radiology services including nuclear medicine and diagnostic ultrasound services.

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a ~~client~~ member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.

(4) Durable medical equipment or medical supplies not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a ~~client~~ member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;

(9) Family planning services provided to individuals enrolled in the Family Planning Waiver;

(10) Optometry and podiatric services other than for dual eligible for Part B of Medicare;

~~(10)~~ (11) Other services that are not defined in this rule or the State Plan.

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:

(1) Physician services are not covered in a hospital.

~~(2) Encounters for PCP/CM covered capitated services provided to eligible SoonerCare Choice members enrolled in the Health Center's panel (except family planning services or HIV/AIDS prevention services) are not reimbursed as an encounter. However, PCP/CM covered services are included in the PPS wrap-around/reconciliation process (refer to OAC 317:30-5-664.11 for specific details).~~

~~(3)~~ (2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240, ~~317:30-5-585,~~ and 317:30-5-595 and contracted with OHCA as an outpatient behavioral health agency.

~~(4)~~ (3) Behavioral health services are limited to those services furnished to members at or on behalf of the Health Center.

317:30-5-664.7. Dental services provided by Health Centers

~~(a) Covered medically necessary preventive dental services provided to adults and children are considered core services.~~

(a) **General**. Medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician are considered core services.

(b) **Adults.** The Health Center core service benefit to SoonerCare Traditional and SoonerCare Choice adults is intended to provide services requiring immediate treatment, relief of pain and/or extraction and is not intended to restore teeth. For scope of services for individuals eligible under other program categories, refer to OAC 317:30-5-696. Core ~~Services~~ services are limited to treatment for conditions such as:

(1) Acute infection;

(2) Acute abscesses;

(3) Severe tooth pain; and
(4) Tooth re-implantation, when clinically appropriate.
~~(c) Other medically necessary dental services which are not considered to be preventive may be billed by the Health Center utilizing the current SoonerCare fee schedule.~~
(c) **Children**. Medically necessary dental services for children are covered.
(d) **Exclusions and Limitations**. Other medically necessary dental services which are not considered core services may be billed by the Health Center utilizing the current SoonerCare fee schedule.
(1) Emergency Extractions are limited to three per day;
(2) Smoking and tobacco use cessation is a covered service for adults and children.
(3) Refer to OAC 317:30-5-695 for other specific coverage, exclusions and prior authorization requirements.
~~(d)~~ (e) Health Centers must submit all claims for SoonerCare reimbursement for dental services on the American Dental Association (ADA) form.

317:30-5-664.10. Health Center reimbursement
(a) In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, ~~effective January 1, 2002,~~ reimbursement is provided for core services, primary behavioral health and other health services at a Health Center facility-specific Prospective Payment System (PPS) rate per visit (encounter) determined according to the methodology described in OAC 317:30-5-664.12.
(b) As claims/encounters are filed, reimbursement for SoonerCare Choice and SoonerCare Traditional members is made for all medically necessary covered primary care ~~services (that are not included in the SoonerCare capitation payment, if applicable)~~ and other health services at the ~~current rate for that CPT/HCPCS code~~ PPS rate.
~~(c) As claims are filed, reimbursement for SoonerCare Traditional members is made for all medically necessary covered primary care and other health services at the PPS rate.~~
~~(d)~~ (c) The originating site facility fee for telemedicine services is not a Federally Qualified Health Center (FQHC) service. When a FQHC serves as the originating site, the originating site facility fee is paid separately from the center's all-inclusive rate.
(d) Primary and preventive behavioral health services rendered by core providers will be reimbursed at the PPS encounter rate.
(e) Non-Core LBHP behavioral health services are reimbursed according to the SoonerCare fee-for-service fee schedule with a maximum of 8 sessions per member per month and 8 units of testing per member per year.
(f) Vision services provided by Optometrists within the scope of their licensure for non dual eligible members and allowed under the Medicaid State Plan are reimbursed pursuant to the SoonerCare fee-for-service fee schedule.

317:30-5-664.11. PPS rate reconciliation to Health Centers [REVOKED]
~~(a) PPS reconciliation/wrap around adjustments will be made for the difference in the facility specific PPS rate and the fee schedule payments.~~
~~(b) OHCA compares the total payments due under the PPS rate per visit method and the payments made under the methods described in OAC 317:30-5-664.10 (b) and (c).~~
~~(c) OHCA will make an adjustment for the difference in the payments allowed and the facility specific PPS rate. The difference in payments will be reconciled not less often than quarterly.~~

6.b-2. CHAPTER 45. INSURE OKLAHOMA~~/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE~~

Subchapter 13. Insure Oklahoma Dental Services

317:45-13-1. [NEW]

(Reference APA WF # 10-32)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Insure Oklahoma program to comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes and the requirements set forth in the Children's Health Insurance Program Reauthorization Act of 2009. Rules are revised to add dental services requirements and benefits for children. The OHCA will provide dental services to children who qualify for the Insure Oklahoma Individual Plan (IP) program. Rules will include requirements and benefits for direct dental coverage. The benefits extended to children will include class A, B, C, orthodontic care, and emergency dental services. All dental services for children will follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. This expansion to the Insure Oklahoma program will increase access to health care for Oklahoma children, thereby reducing the amount of uncompensated care provided by health care providers.

ANALYSIS: Insure Oklahoma rules are revised to add dental services requirements and benefits for children. The Oklahoma Health Care Authority (OHCA), as a requirement of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), will provide dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Rules will include requirements and benefits for direct dental coverage. The benefits extended to children will include class A, B, C, orthodontic care, and emergency dental services. All dental services for children will follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule.

BUDGET IMPACT: Agency staff has determined that the rule revisions will cost approximately $1,312,200 total dollars; State share approximately $460,057.32 for SFY 2011. The state share will be provided from the unused funds from the HEEIA Revolving Fund.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on July 15, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:

Revise Insure Oklahoma rules to add dental services requirements and benefits for children as required by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

SUBCHAPTER 13. INSURE OKLAHOMA DENTAL SERVICES

317:45-13-1. Dental services requirements and benefits

The Oklahoma Health Care Authority (OHCA) provides dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Dental coverage is obtained through direct purchase from the OHCA. The existing cost sharing requirements for IP qualified children apply. Children obtaining medical coverage through IP receive Dental IP coverage. The OHCA contracts with Dental IP providers utilizing the SoonerCare network. The Dental IP providers are reimbursed pursuant to the SoonerCare fee schedule for rendered services.

(1) The Dental IP program is covered as medically necessary and includes coverage for Class A, B, C, and orthodontia services. All coverage is provided as necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Dental services follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. Prior authorization is required for certain services.

(2) Class A services are covered as medically necessary and include preventive, diagnostic care such as cleanings, check-ups, X-rays, and fluoride treatments, no co-pay is required.

(3) Class B services are covered as medically necessary and include basic, restorative, endodontic, periodontic, oral and maxillofacial surgery care such as fillings, extractions, periodontal care, and some root canal, $10 co-pay is required.

(4) Class C services are covered as medically necessary and include major, prosthodontic care such as crowns, bridges and dentures, $25 co-pay is required.

(5) Class D services are covered as medically necessary and include orthodontic care. Orthodontic care is not covered for cosmetic purposes or any purposes which are not medical in nature, $25 co-pay is required.

(6) Emergency dental services are covered as medically necessary, no co-pay is required.

6.b-3. CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
Subchapter 5. Sooner Seniors
317:50-5-1. through 317:50-5-16. [NEW]
(Reference APA WF # 10-40)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to include language allowing for a new Home and Community Based Services Waiver program known as Sooner Seniors. The Sooner Seniors Waiver is targeted to members who are age 65 or older, have a clinically documented degenerative disease process and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional services in a home setting. The program is more cost effective than institutionalized care, therefore, a substantial savings will be realized over time through operation of this Waiver.

ANALYSIS: Rules are revised to include language allowing for a new Home and Community Based Services Waiver. The Sooner Seniors Waiver is targeted to members who are age 65 or older, have a clinically documented degenerative disease process and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new waiver allows members to continue receiving the same home and community based services offered through Living Choice.

BUDGET IMPACT: Agency staff has determined that the rule revisions will cost approximately $159,072 Total dollars, SFY 2011; State share approximately $39,529

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on July 15, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise agency rules to include language allowing for a new Home and Community Based Services Waiver targeting members who are age 65 or older, have a clinically documented degenerative disease process and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program.

SUBCHAPTER 5. SOONER SENIORS

317:50-5-1. Purpose

The Sooner Seniors Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for a targeted group of elderly individuals. To be considered for Sooner Seniors Waiver Program services, individuals must meet all criteria set forth under 317:50-5-3.

317:50-5-2. Definitions

The following words and terms when used in this subchapter, shall 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 getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

(2) **"ADLs score in high risk range"** means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

(3) **"ADLs score at the high end of the moderate risk range"** means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

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

(5) **"Environment high risk"** means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(6) **"Environment moderate risk"** means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

(7) **"Health Assessment high risk"** means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

(8) **"Health Assessment low risk"** means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the Sooner Seniors program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

(9) **"Health Assessment moderate risk"** means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

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

(11) **"IADLs score in high risk range"** means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

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

(A) shopping,

(B) cooking,

(C) cleaning,

(D) managing money,

(E) using a telephone,

(F) doing laundry,

(G) taking medication, and

(H) accessing transportation.

(13) **"Member Support high risk"** means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

(14) **"Member Support moderate risk"** means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

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

(16) **"MSQ"** means the mental status questionnaire.

(17) **"MSQ score in high risk range"** means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

(18) **"MSQ score at the high end of the moderate risk range"** means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an

orientation-memory-concentration impairment, or a significant memory impairment.

(19) **"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

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

(21) **"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.

317:50-5-3. Sooner Seniors program overview

(a) The Sooner Seniors program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for a targeted group of elderly adults. Sooner Seniors services are outside the scope of state plan Medicaid services. The Waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized.

(1) To be considered for Sooner Seniors services, individuals must meet the following criteria:

(A) be age 65 years or older;

(B) have a clinically documented, progressive degenerative disease process that responds to treatment and requires Sooner Seniors Waiver services to maintain the treatment regimen to prevent health deterioration and remain in a home and community based setting;

(C) have transitioned to a home and community based setting through the Living Choice Program;

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

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or

(II) MSQ score is at the high end of moderate risk range; or

(III) IADLs score is in the high risk range; or

(IV) Nutrition score is in the high risk range; or

(V) Health Assessment is in the moderate risk range, and, in addition;

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Individual Support is moderate risk; or

(ii) Environment is high risk; or

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;

(C) The UCAT documents that:

(i) the individual has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:50-5-3(a)(2)(A) criteria if untreated; and

(ii) the individual previously has required hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and

(iv) only by means of Sooner Seniors Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services**. To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

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

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

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

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

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

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

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

(4) Meet service eligibility criteria [see OAC 317:50-5-3(c)].

(5) Meet program eligibility criteria [see OAC 317:50-5-3(d)].

(b) Services provided through the Sooner Seniors Waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy;

(7) occupational therapy;

(8) respiratory therapy;

(9) speech therapy;

(10) dental services and treatment up to $1,000 annually;

(11) family training services;

(12) nutritional education services;

(13) vision services;

(14) pharmacological evaluations;

(15) agency companion;

(16) advanced supportive/restorative assistance;

(17) skilled nursing and private duty nursing;

(18) home delivered meals;

(19) hospice care;

(20) medically necessary prescription drugs within the limits of the waiver;

(21) personal care (state plan), Sooner Seniors personal care;

(22) Personal Emergency Response System (PERS);
(23) Self-directed services;
(24) All other SoonerCare medical services within the scope of the State Plan, including SoonerRide non-emergency transportation.

(c) A service eligibility determination is made using the following criteria:
(1) an open Sooner Seniors Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Sooner Seniors Waiver slots are filled, the individual cannot be certified as eligible for Sooner Seniors Waiver services and the individual's name is placed on a waiting list for entry as an open slot becomes available. Sooner Seniors Waiver slots and corresponding waiting lists, if necessary, are maintained.
(2) the individual is in the Sooner Seniors Waiver targeted service group. The target group is an individual who is age 65 or older with a chronic medical condition.
(3) the individual does not pose a physical threat to self or others as supported by professional documentation.
(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(d) The Sooner Seniors Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:
(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through Sooner Seniors Waiver program services, SoonerCare State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Sooner Seniors Waiver program or SoonerCare State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.
(2) if the individual poses a physical threat to self or others as supported by professional documentation.
(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.
(4) if the individual's needs are being met, or do not require Sooner Seniors Waiver services to be met, or if the individual would not require institutionalization if needs are not met.
(5) if, after the service plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

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

(f) Individuals determined ineligible for Sooner Seniors Waiver program services are notified in writing of the determination and of their right to appeal the decision.

317:50-5-4. Application for Sooner Seniors Waiver services

(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the Sooner Seniors Waiver. In order to transition from the Living Choice demonstration program to the Sooner Seniors Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the Sooner Seniors Waiver. The original application and eligibility processes are set forth in 317:50-5-4(a)(1) through 317:50-5-6 below.

(1) The application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Sooner Seniors Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(A) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such 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) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(c) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the Sooner Seniors waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(b) **Sooner Seniors Waiver waiting list procedures.** Sooner Seniors Waiver Program "available capacity in the month" is the number of additional members that may be enrolled in the Program in a given month without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year.

317:50-5-5. Sooner Seniors Waiver program medical eligibility determination

A medical eligibility determination is made for Sooner Seniors Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has unmet care needs that require Sooner Seniors Waiver Program, or NF level services to assure member health and safety. Sooner Seniors Waiver services are designed to be a continuation of support for the informal care that is being provided in the member's home. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Sooner Seniors Waiver service provision will supplement the system within the limitations of Sooner Seniors Waiver Program policy.

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

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

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

(5) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety, OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(6) Within ten (10) working days of receipt of a complete Sooner Seniors Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria

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

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

(9) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.

317:50-5-6. Determining financial eligibility for the Sooner Seniors Waiver program

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

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

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

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

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

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

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

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

(2) **Individual with a spouse who receives HCBW services, or—is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of HCBW program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBW program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a

mental health hospital. The income of either spouse is not considered as available to the other during the receipt of Sooner Seniors Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:

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

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

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

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

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

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

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

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

(A) **Income eligibility**. To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

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

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

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

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

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

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

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

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS form 08AX001E, Schedule XI.

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

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

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

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder

considered available to the spouse receiving Sooner Seniors Waiver program services.

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

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the Sooner Seniors Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

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

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

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

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

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

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

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

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

have been multiple transfers, all transferred assets are added together to determine the penalty.

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

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

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

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

(I) the spouse;

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

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

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

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

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

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

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

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

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

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of Sooner Seniors Waiver program services and the continuance of eligibility for other SoonerCare services.

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

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

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

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

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

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

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

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

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

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

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

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

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

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

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

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

(ii) Inheritance from a spouse.

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

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

(H) A penalty would not apply if:

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

(I) the spouse; or

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

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

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

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

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

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

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

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

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

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

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

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

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a

process for an adverse determination appeal. The notice explains the period of ineligibility for payment of Sooner Seniors Waiver program services and the continuance of eligibility for other SoonerCare services.

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

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

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

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

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

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

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

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

317:50-5-7. Certification for Sooner Seniors Waiver program services

(a) **Financial certification period for Sooner Seniors Waiver program services.** The financial certification period for the Sooner Seniors Waiver program is 12 months.

(b) **Medical Certification period for Sooner Seniors Waiver program services.** The medical certification period for Sooner Seniors Waiver program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more than 12 months, an independent evaluation of medical eligibility is completed before the end of the current medical certification period.

317:50-5-8. Redetermination of eligibility for Sooner Seniors Waiver services

A redetermination of medical and financial eligibility must be completed prior to the end of the certification period.

317:50-5-9. Member annual level of care re-evaluation and annual re-authorization of service plan

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

(b) At a maximum of every 11 months, the case manager makes a home visit to evaluate the Sooner Seniors Waiver member using the UCAT, Parts I and III and other information as necessary as part of the annual service plan development process.

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

(2) As part of the service plan recertification process, the member is evaluated for the continued need for Nursing Facility level of care.

(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's "medical eligibility end date" is updated in the system. The member's case manager is notified that the member has been determined to no longer meet medical eligibility for Sooner Seniors Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of Sooner Seniors Waiver services.

317:50-5-10. Sooner Seniors Waiver services during hospitalization or nursing facility placement

If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.

(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers and coordinates the resumption of Sooner Seniors Waiver services in the home.

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the member's case manager expedites the restart of Sooner Seniors Waiver services for the member.

317:50-5-11. Closure or termination of Sooner Seniors Waiver services

(a) **Voluntary closure of Sooner Seniors Waiver services**. If the member requests a lower level of care than Sooner Seniors Waiver services or if the member agrees that Sooner Seniors Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.

(b) **Closure due to financial or medical ineligibility**. The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility**. Anytime it is determined that a member does not meet the financial eligibility criteria, the member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

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

(c) **Closure due to other reasons**. Refer to OAC 317:50-5-3(d).

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

317:50-5-12. Eligible providers

Sooner Seniors Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file.

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

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

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

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

(5) Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, and NF Respite services do not have a programmatic evaluation after the initial certification.

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

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

(i) either no other provider is available; or

(ii) available providers are unable to provide necessary care to the member; or

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

(B) The service must:

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

(ii) be necessary to avoid institutionalization;

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) In addition to case management, monitoring, and reporting activities required for all Waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The OHCA will monitor through documentation submitted by the Case Manager the following:

(i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual member; and

(ii) face-to-face visits with the member by the Case Manager on at least a semi annual basis.

(7) The OHCA periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), and Self-Directed service providers. If due to a programmatic audit, a provider Plan of Correction is required, the OHCA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the OHCA, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.
(8) As additional providers are certified or if a provider loses certification, the OHCA provides notice to appropriate personnel in counties affected by the certification changes.

317:50-5-13. Coverage

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

(1) To allow for development of administrative structures and provider capacity to adequately deliver Self-Directed services and Supports, availability of Self-Direction is limited to Sooner Seniors Program members that reside in counties that have sufficient provider capacity to offer the Self-Directed Service option as determined by OHCA.
(2) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information and material on Self-Direction to Case Managers for distribution to members.
(3) The member may request to Self-Direct their services from their Case Manager or call the Sooner Seniors Program toll-free number to request the Self-Directed Services option.

317:50-5-14. Description of services

Services included in the Sooner Seniors Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is

discharged from the institution. Case Managers must meet Sooner Seniors Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

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

(i) A billable case management activity is any task or function defined under OAC 317:50-5-14(1)(A) that only a Sooner Seniors case manager because of skill, training or authority, can perform on behalf of a member;

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

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

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

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

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

(2) **Respite.**

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

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

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

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

(3) **Environmental Modifications.**

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

(B) All services require prior authorization.

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

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

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

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

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

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

(6) **Nursing.**

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

nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

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

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

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

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

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

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

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

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

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

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

and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

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

(7) **Home Delivered Meals.**

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

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

(8) **Occupational Therapy services.**

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

services, based on the member's condition and ongoing rehabilitation potential.

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

(9) **Physical Therapy services.**

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

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

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

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

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

(11) **Respiratory Therapy services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility.

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

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

(12) **Hospice services.**

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

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

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

(A) Sooner Seniors Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and

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

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

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

(14) **Adult Day Health**. Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member. Transportation between the member's place of residence and the adult day facility is provided and is included in the rate paid to providers of adult day health services.

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

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

(A) oral examination;

(B) bite-wing x-rays;

(C) prophylaxis;

(D) topical fluoride treatment;

(E) development of a sequenced treatment plan that prioritizes:

(i) elimination of pain;

(ii) adequate oral hygiene; and

(iii) restoration or improved ability to chew;

(F) routine training of member or primary caregiver regarding oral hygiene; and

(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

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

(18) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional

health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

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

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

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

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

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

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

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

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

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

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

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

(22) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:

(A) An initial medication assessment performed in conjunction with the case manager and member.

(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.

(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.

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

(24) **Self-Direction.**

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

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

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

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

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

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

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

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the

first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

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

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

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

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

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

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

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

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

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

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

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

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

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

Services Individualized Budget Allocation Expenditure Accounts Determination Process.

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

317:50-5-15. Reimbursement

Rate methodologies for Waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board. Rates for Waiver services are set by one of the methodologies below:

(1) A fixed and uniform SoonerCare Rate. When a Waiver service is similar or the same as a Medicaid State Plan service for which a fee schedule has been established, the current SoonerCare rate is utilized.

(3) The current Medicare rate. When the waiver service mirrors an existing Medicare service the current Medicare rate is utilized.

(3) Individual rates. Certain services because of their variables do not lend themselves to a fixed and uniform rate. Payment for these services is made on an individual basis following a uniform process approved by the OHCA.

317:50-5-16. Billing procedures for Sooner Seniors Waiver services

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The approved Sooner Seniors Waiver service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) As part of Sooner Seniors Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.

(d) Service time of Personal Care, Case Management, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite and Self Direction may be documented through the Interactive Voice Response Authentication (IVRA) system when provided in the home. 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 agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

6.b-4. CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
Subchapter 3. My Life, My Choice
317:50-3-1. through 317:50-3-16. [NEW]
(Reference APA WF # 10-41)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to include language allowing for a new Home and Community Based Services Waiver program known as My Life, My Choice. The My Life, My Choice Waiver is targeted to members who are 20 through 64 years of age, are physically disabled and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional services in a home setting. The program is more cost effective than institutionalized care; therefore a substantial savings will be realized over time through operation of this Waiver.

ANALYSIS: Rules are revised to include language allowing for a new Home and Community Based Services Waiver program. The My Life, My Choice Waiver is targeted to members who are 20 through 64 years of age, have a physical disability and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new waiver allows members to continue receiving the same home and community based services offered through Living Choice.

BUDGET IMPACT: Agency staff has determined that the rule revisions will cost approximately $798,840 Total dollars, SFY 2011; State share approximately $198,511

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on July 15, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Agency rules to include language allowing for a new Home and Community Based Services Waiver program targeted to members who are 20 through 64 years of age, have a physical disability and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program.

SUBCHAPTER 3. My Life, My Choice

317:50-3-1. Purpose

The My Life, My Choice Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for a targeted group of physically disabled individuals. To be considered for My Life, My Choice Waiver Program services, individuals must meet the basic criteria set forth under 317:50-3-3.

317:50-3-2. Definitions

The following words and terms when used in this subchapter, shall 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 getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

(2) **"ADLs score in high risk range"** means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

(3) **"ADLs score at the high end of the moderate risk range"** means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

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

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

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the individual attains age 22;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity:
(E) self-care;
(F) receptive and expressive language;
(G) learning;
(H) mobility;
(I) self-direction;
(J) capacity for independent living;
(L) economic self-sufficiency; and

(M) reflects the individual=s need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

(6) **"Environment high risk"** means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(7) **"Environment moderate risk"** means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

(8) **"Health Assessment high risk"** means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

(9) **"Health Assessment low risk"** means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the My Life, My Choice program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

(10) **"Health Assessment moderate risk"** means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

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

(12) **"IADLs score in high risk range"** means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

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

(A) shopping,

(B) cooking,

(C) cleaning,

(D) managing money,

(E) using a telephone,

(F) doing laundry,

(G) taking medication, and

(H) accessing transportation.

(14) **"Member Support high risk"** means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services,

very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.
(15) **"Member Support moderate risk"** means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.
(16) **"Mental Retardation"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.
(17) **"MSQ"** means the mental status questionnaire.
(18) **"MSQ score in high risk range"** means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.
(19) **"MSQ score at the high end of the moderate risk range"** means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.
(20) **"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.
(21) **"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.
(22) **"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.

317:50-3-3. My Life, My Choice program overview

(a) The My Life, My Choice program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for a targeted group of physically disabled adults. My Life, My Choice services are outside the scope of state plan Medicaid services. The Waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized.

(1) To be considered for My Life, My Choice services, individuals must meet the following criteria:

(A) be 20 to 64 years of age;

(B) be physically disabled; and

(C) have transitioned to a home and community based setting through the Living Choice Program;

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

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or

(II) MSQ score is at the high end of moderate risk range; or

(III) IADLs score is in the high risk range; or

(IV) Nutrition score is in the high risk range; or

(V) Health Assessment is in the moderate risk range, and, in addition;

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Individual Support is moderate risk; or

(ii) Environment is high risk; or

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;

(C) The UCAT documents that:

(i) the individual has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:50-3-3(a)(2)(A) criteria if untreated; and

(ii) the individual previously has required hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and

(iv) only by means of My Life, My Choice Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services**. To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

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

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

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

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

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

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

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

(4) Meet service eligibility criteria [see OAC 317:50-3-3(c)].

(5) Meet program eligibility criteria [see OAC 317:50-3-3(d)].

(b) Services provided through the My Life, My Choice Waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;
(6) physical therapy;
(7) occupational therapy;
(8) respiratory therapy ;
(9) speech therapy;
(10) assistive technology;
(11) audiology treatment and evaluation;
(12) dental services and treatment up to $1,000 annually;
(13) family counseling;
(14) family training;
(15) independent living skills training;
(16) nutrition services;
(17) psychiatry;
(18) psychological services;
(19) vision services;
(20) pharmacological evaluations;
(21) agency companion;
(22) advanced supportive/restorative assistance;
(23) skilled nursing and private duty nursing;
(24) home delivered meals;
(25) hospice care;
(26) medically necessary prescription drugs within the limits of the waiver;
(27) personal care (state plan), or My Life, My Choice personal care;
(28) Personal Emergency Response System (PERS);
(29) Self-directed services;
(30) all other SoonerCare medical services within the scope of the State Plan, including SoonerRide non-emergency transportation.

(c) A service eligibility determination is made using the following criteria:
(1) an open My Life, My Choice Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all My Life, My Choice Waiver slots are filled, the individual cannot be certified as eligible for My Life, My Choice Waiver services and the individual's name is placed on a waiting list for entry as an open slot becomes available. My Life, My Choice Waiver slots and corresponding waiting lists, if necessary, are maintained.
(2) the individual is in the My Life, My Choice Waiver targeted service group. The target group is an individual who is age 20 to 64 with a physical disability.
(3) the individual does not pose a physical threat to self or others as supported by professional documentation.
(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(d) The My Life, My Choice Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:
(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through My Life, My Choice Waiver program services, SoonerCare State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of My Life, My Choice Waiver program or SoonerCare

State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

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

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

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

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

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

(f) Individuals determined ineligible for My Life, My Choice Waiver program services are notified in writing of the determination and of their right to appeal the decision.

317:50-3-4. Application for My Life, My Choice Waiver services

(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the My Life, My Choice Waiver. In order to transition from the Living Choice demonstration program to the My Life, My Choice Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the My Life, My Choice Waiver. The original application and eligibility processes are set forth in 317:50-3-4(a)(1) through 317:50-3-6 below.

(1) The application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for My Life, My Choice Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(A) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such 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) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or

as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(c) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the My Life, My Choice waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

(2) The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(b) **My Life, My Choice Waiver waiting list procedures.** My Life, My Choice Waiver Program "available capacity in the month" is the number of additional members that may be enrolled in the Program in a given month without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year.

317:50-3-5. My Life, My Choice Waiver program medical eligibility determination

A medical eligibility determination is made for My Life, My Choice Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has unmet care needs that require My Life, My Choice Waiver Program, or NF level services to assure member health and safety. My Life, My Choice Waiver services are designed to be a continuation of support for the informal care that is being provided in the member's home. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, My Life, My Choice Waiver service provision will supplement the system within the limitations of My Life, My Choice Waiver Program policy.

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

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

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

(5) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety,

OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(6) Within ten (10) working days of receipt of a complete My Life, My Choice Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria.

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

(8) If the member has a current certification and requests a change to My Life, My Choice Waiver services, a new UCAT is required. The UCAT is also updated when a member requests a change from My Life, My Choice Waiver services to State Plan Personal Care services. If a member is receiving My Life, My Choice Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(9) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.

317:50-3-6. Determining financial eligibility for the My Life, My Choice Waiver program

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

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

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

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

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

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for My Life, My Choice Waiver services. If the individual's gross income exceeds

that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

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

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

(2) **Individual with a spouse who receives HCBW services, or——is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of HCBW program services.

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

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

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

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

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

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

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

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for

the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

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

(A) **Income eligibility**. To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the My Life, My Choice Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

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

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving My Life, My Choice Waiver program services is likely to remain under care for 30

consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

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

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

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

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

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

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

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

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

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

(I) the spouse;

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

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

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

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

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

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

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

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

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

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of My Life, My Choice Waiver program services and the continuance of eligibility for other SoonerCare services.

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

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

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

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

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

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

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

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

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

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

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

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

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's

resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

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

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

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

(ii) Inheritance from a spouse.

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

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

(H) A penalty would not apply if:

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

(I) the spouse; or

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

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

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

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

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

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The

transfer may be to a trust established for the benefit of the individual's child.

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

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

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

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

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

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

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

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

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

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

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

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

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

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer

subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

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

317:50-3-7. Certification for My Life, My Choice Waiver program services

(a) **Financial certification period for My Life, My Choice Waiver program services**. The financial certification period for the My Life, My Choice Waiver program is 12 months.

(b) **Medical Certification period for My Life, My Choice Waiver program services**. The medical certification period for My Life, My Choice Waiver program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more than 12 months, an independent evaluation of medical eligibility is completed before the end of the current medical certification period.

317:50-3-8. Redetermination of eligibility for My Life, My Choice Waiver services

A redetermination of medical and financial eligibility must be completed prior to the end of the certification period.

317:50-3-9. Member annual level of care re-evaluation and annual re-authorization of service plan

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

(b) At a maximum of every 11 months, the case manager makes a home visit to evaluate the My Life, My Choice Waiver member using the UCAT, Parts I and III and other information as necessary as part of the annual service plan development process.

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

(2) As part of the service plan recertification process, the member is evaluated for the continued need for Nursing Facility level of care.

(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current

medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's "medical eligibility end date" is updated in the system. The member's case manager is notified that the member has been determined to no longer meet medical eligibility for My Life, My Choice Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of My Life, My Choice Waiver services.

317:50-3-10. My Life, My Choice Waiver services during hospitalization or nursing facility placement

If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.

(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers and coordinates the resumption of My Life, My Choice Waiver services in the home.

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the member's case manager expedites the restart of My Life, My Choice Waiver services for the member.

317:50-3-11. Closure or termination of My Life, My Choice Waiver services

(a) **Voluntary closure of My Life, My Choice Waiver services**. If the member requests a lower level of care than My Life, My Choice Waiver services or if the member agrees that My Life, My Choice Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.

(b) **Closure due to financial or medical ineligibility**. The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility**. Anytime it is determined that a member does not meet the financial eligibility criteria, the member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

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

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

(d) **Resumption of My Life, My Choice Waiver services.** If a member approved for My Life, My Choice Waiver services has been without services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service

plan. If a member decides he/she desires to have his/her services restarted after 90 days, the member must request the services.

317:50-3-12. Eligible providers

My Life, My Choice Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file.

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

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

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

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

(5) Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, and NF Respite services do not have a programmatic evaluation after the initial certification.

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

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

(i) either no other provider is available; or

(ii) available providers are unable to provide necessary care to the member; or

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

(B) The service must:

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

(ii) be necessary to avoid institutionalization;

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) In addition to case management, monitoring, and reporting activities required for all Waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The OHCA will monitor through documentation submitted by the Case Manager the following:

(i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual member; and

(ii) face-to-face visits with the member by the Case Manager on at least a semi annual basis.

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

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

317:50-3-13. Coverage

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

(1) To allow for development of administrative structures and provider capacity to adequately deliver Self-Directed services and Supports,

availability of Self-Direction is limited to My Life, My Choice Program members that reside in counties that have sufficient provider capacity to offer the Self-Directed Service option as determined by OHCA.
(2) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information and material on Self-Direction to Case Managers for distribution to members.
(3) The member may request to Self-Direct their services from their Case Manager or call the My Life, My Choice Program toll-free number to request the Self-Directed Services option.

317:50-3-14. Description of services

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

(1) **Case Management.**

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

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

(i) A billable case management activity is any task or function defined under OAC 317:50-3-14(1)(A) that only a My Life, My Choice case manager because of skill, training or authority, can perform on behalf of a member;

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

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

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities

provided to a member who resides in a county with population density greater than 25 persons per square mile.

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

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

(2) **Respite.**

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

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

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

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

(3) **Environmental Modifications.**

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

(B) All services require prior authorization.

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

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

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

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

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

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

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

(6) **Nursing.**

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

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

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

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

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

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

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

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

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

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

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

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

(7) **Home Delivered Meals.**

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

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

(8) **Occupational Therapy services.**

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

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

(9) **Physical Therapy services.**

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

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

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

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

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

(11) **Respiratory Therapy services.**

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

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

(12) **Hospice services**.

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and

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

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

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

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

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

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

(14) **Adult Day Health**. Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member. Transportation between the member's place of residence and the adult day facility is provided and is included in the rate paid to providers of adult day health services.

(15) **Assistive Technology**. Assistive technology enables the member to maintain or increase functional capabilities. Assistive technology devices are in addition to equipment and supplies readily available through traditional State Plan services and exclude items that are not of direct medical or remedial benefit to the member. Assistive technology includes the purchase, rental, customization, maintenance and repair of such devices.

(16) **Audiology Treatment and Evaluation.** Services include evaluation, treatment and consultation related to auditory functioning and are intended to maximize the member's hearing abilities.

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

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

(A) oral examination;

(B) bite-wing x-rays;

(C) prophylaxis;

(D) topical fluoride treatment;

(E) development of a sequenced treatment plan that prioritizes:

(i) elimination of pain;

(ii) adequate oral hygiene; and

(iii) restoration or improved ability to chew;

(F) routine training of member or primary caregiver regarding oral hygiene; and

(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(26) **Psychiatry.** Psychiatry provides outpatient psychiatric services provided by a licensed psychiatrist and will be comprised of diagnosis, treatment and prevention of mental illness. These services will also include review, assessment and monitoring of psychiatric conditions,

evaluation of the current plan of treatment and recommendations for a continued and/or revised plan of treatment and/or therapy, including required documentation. Psychiatrists may provide instruction and training to individuals, family members, case management staff and/or provider staff in recognition of psychiatric illness and adverse reactions to medications.

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

(28) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:

(A) An initial medication assessment performed in conjunction with the case manager and member.

(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.

(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.

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

(30) **Self-Direction**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

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

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

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

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

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

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

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

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

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

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

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

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

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

(H) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.
(I) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.
(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

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

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

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

317:50-3-15. Reimbursement

Rate methodologies for Waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board. Rates for Waiver services are set by one of the methodologies below:

(1) A fixed and uniform SoonerCare Rate. When a Waiver service is similar or the same as a Medicaid State Plan service for which a fee schedule has been established, the current SoonerCare rate is utilized.

(3) The current Medicare rate. When the waiver service mirrors an existing Medicare service the current Medicare rate is utilized.

(3) Individual rates. Certain services because of their variables do not lend themselves to a fixed and uniform rate. Payment for these services is made on an individual basis following a uniform process approved by the OHCA.

317:50-3-16. Billing procedures for My Life, My Choice Waiver services

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The approved My Life, My Choice Waiver service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) As part of My Life, My Choice Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.

(d) Service time of Personal Care, Case Management, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite and Self Direction may be documented through the Interactive Voice Response Authentication (IVRA) system when provided in the home. 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 agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

Submitted to the C.E.O. and Board on August 25, 2010
AUTHORITY FOR EXPENDITURE OF FUNDS
MMIS REPROCUREMENT

BACKGROUND

Hewlett-Packard Enterprise Services (HP) was awarded the contract as OHCA's fiscal agent in October 2000 to implement and operate a new Medicaid Management Information System (MMIS). This contract expires December 31, 2011.

SCOPE OF WORK

OHCA has released a Request for Proposal (RFP) to obtain a vendor to take over the current fiscal agent responsibilities, enhance, and operate the existing MMIS. The MMIS enhancements include:

- Federal mandates for new claim formats, new diagnosis codes, and health information exchange.
- New edit and audit functions for MMIS claims processing.
- Better integration of the Atlantes Care Management system with the MMIS.
- Improvements to online enrollment and eligibility.
- Insure Oklahoma expansion and improvements.
- Rules engines to provide efficiency and flexibility in claims processing.

The RFP also includes a Program Integrity (PI) system with new technologies for fraud detection and case tracking. This system may be awarded to the MMIS vendor or to a different PI System vendor.

CONTRACT PERIOD

OHCA anticipates making a vendor recommendation about September 21, 2010 and CMS approval about November 21, 2010. The contract has a development period, operational period, and optional one-year extension.

CONTRACT	START DATE	END DATE
System Development	November 21, 2010	December 31, 2011
Operations	January 1, 2012	December 31, 2016
Optional Extension	January 1, 2017	December 31, 2017

CONTRACT AMOUNT AND PROCUREMENT METHOD

- OHCA will procure these services by competitive bid.
- The anticipated cost, including MMIS takeover, enhancements, and operations for an approximately eight-year period (through state fiscal year 2018), is estimated at $300 million or about $38 million each year. The federal matching percentages are 50%, 75% and 90% depending on the nature of the expenditures. More detailed budget estimates are included on page 3 of this document.

SFY	State Funds	Federal Funds	Total Funds
2011	$3,806,955	$13,316,945	$17,123,900
2012	$9,017,134	$23,641,044	$32,658,178
2013	$12,935,342	$31,716,231	$44,651,573
2014	$13,142,608	$31,877,884	$45,020,492
2015	$13,250,468	$30,428,037	$43,678,505
2016	$13,822,217	$30,813,521	$44,635,738
2017	$14,807,476	$33,191,073	$47,998,549
2018	$7,679,455	$17,264,316	$24,943,771

RECOMMENDATION

- Board approval to expend funds to procure a new MMIS vendor and Program Integrity system.
- Board approval is contingent upon approval by CMS.

MMIS Funding	*SFY* 2011	*SFY* 2012	*SFY* 2013	*SFY* 2014	*SFY* 2015	*SFY* 2016	*SFY* 2017	*SFY* 2018	Total
MMIS Takeover and Mandates									
90 % Federal Share	6,126,770	4,491,398	4,718,133	4,302,432	1,594,937	0	0	0	20,960,090
10 % State Share	680,752	499,044	524,237	478,048	177,215	0	0	0	2,328,899
	6,807,522	**4,990,443**	**5,242,370**	**4,780,480**	**1,772,152**	**0**	**0**	**0**	**23,288,989**
Enhanced Operations									
75 % Federal Share	7,190,175	18,034,191	24,733,725	25,243,149	26,430,827	28,339,180	30,642,501	15,971,199	178,086,554
25 % State Share	2,396,725	6,011,397	8,244,575	8,414,383	8,810,276	9,446,393	10,214,167	5,323,733	59,362,184
	9,586,900	**24,045,588**	**32,978,300**	**33,657,532**	**35,241,103**	**37,785,573**	**40,856,668**	**21,294,932**	**237,448,737**
Medicaid Operations									
50% Federal Share	0	1,115,454	2,264,373	2,332,304	2,402,273	2,474,341	2,548,571	1,293,117	14,430,433
50% State Share	0	1,115,454	2,264,373	2,332,304	2,402,273	2,474,341	2,548,571	1,293,117	14,430,433
	0	**2,230,909**	**4,528,745**	**4,664,607**	**4,804,546**	**4,948,682**	**5,097,143**	**2,586,235**	**28,860,867**
Total Federal Matching Funds									
Federal Share	13,316,945	23,641,044	31,716,231	31,877,884	30,428,037	30,813,521	33,191,073	17,264,316	213,477,077
State Share	3,077,477	7,625,896	11,033,185	11,224,735	11,389,764	11,920,734	12,762,738	6,616,850	74,423,354
	16,394,422	**31,266,940**	**42,749,416**	**43,102,619**	**41,817,801**	**42,734,255**	**45,953,811**	**23,881,167**	**287,900,430**
CHIP & State Funds									
State Share	729,478	1,391,238	1,902,157	1,917,873	1,860,704	1,901,482	2,044,738	1,062,605	12,810,276
Total Funds	**17,123,900**	**32,658,178**	**44,651,573**	**45,020,492**	**43,678,505**	**44,635,738**	**47,998,549**	**24,943,771**	**300,710,707**