OKLAHOMA HEALTH CARE AUTHORITY
REGULAR SCHEDULED BOARD MEETING
February 14, 2019 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

A G E N D A

Items to be presented by Anthony Armstrong, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the January 10, 2019 OHCA Board Meeting Minutes

Item to be presented by Becky Pasternik-Ikard, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) All-Star Recognition
      - November All-Star – Carolyn Reconnu-Shoffner, Assistant Director of Care Management
      - December All-Star – Tony Russell, Manager of Behavioral Health Services

   b) Financial Update – Aaron Morris, Chief Financial Officer

   c) Medicaid Director's Update – Becky Pasternik-Ikard, CEO

   d) Chief Medical Officer Update – Mike Herndon, Chief Medical Officer

   e) Insure Oklahoma Update – Melissa McCully, Director of Insure Oklahoma

   f) Hemophilia Overview – Jill Ratterman, Clinical Pharmacist and Carolyn Reconnu-Shoffner, Assistant Director of Care Management

Item to be presented by Nicole Nantois, Chief of Legal Services

4. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

Item to be presented by Nicole Nantois, Chief of Legal Services

5. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Permanent Rules:

The following permanent rules HAVE NOT previously been approved by the Board.

A. AMENDING agency rules at ***OAC 317:35-5-42*** will align policy with federal law. Federal law excludes, for nine months, following the month of receipt, the unspent portion of any Social Security Retirement, Survivors, and Disability Insurance (RSDI) or Supplemental Security Income (SSI) retroactive payment when determining the resources of an eligible individual and spouse. According to the regulations, a retroactive payment is one that is paid after the month in which it was due.

Budget Impact: Budget neutral

(Reference APA WF # 18-05)

B. AMENDING agency rules at ***OAC 317:30-5-95.1*** and ***317:30-5-95.34*** will establish a prior authorization requirement for inpatient psychiatric services for adults. The proposed revisions will also align the time requirement of the first individual treatment by the physician to be within the sixty (60) hour requirement of completion of the psychiatric evaluation for Acute and Psychiatric Residential Treatment Facilities (PRTFs) settings. Other revisions will involve limited rewriting aimed at clarifying text.
Budget Impact: Budget neutral

(Reference APA WF # 18-06)

C. AMENDING agency rules at ***OAC 317:30-3-28*** will outline how to qualify for the Electronic Health Records (EHR) Incentive Program by changing the timeframe in which hospitals must meet SoonerCare patient volume criteria for a continuous 90-day period from the preceding calendar year to the preceding federal fiscal year. The proposed revisions also add a 30-day time limit for eligible providers to submit documentation or make corrections to avoid denial of their EHR attestation.
Budget Impact: Budget neutral

(Reference APA WF # 18-10)

D. AMENDING agency rules at ***OAC 317:35-5-4***, ***317:35-5-4.1***, ***317:35-5-49***, and ***317:35-7-61.1*** will remove references to "OKDHS worker" and "local county office" within the Tax Equity and Fiscal Responsibility Act (TEFRA) policy and the policy entitled "Determining categorical relationship to the disabled". The references to said titles will be replaced with "the Oklahoma Health Care Authority (OHCA)" in those instances when the policy is referencing the TEFRA program or the Level of Care Evaluation Unit (LOCEU) at OHCA. Currently, TEFRA applications are processed entirely by the OHCA. Additionally, revisions add new language, to reflect current business practices, which states the family is required to declare their household income to determine if the child is eligible for TEFRA or SoonerCare. Finally, the revisions will remove a section entitled "Specialist's examination" because the policy is obsolete.
Budget Impact: Budget neutral

(Reference APA WF # 18-12)

E. AMENDING agency rules at ***OAC 317:35-21-1***, ***317:35-21-3 through 317:35-21-6***, ***317:35-21-9***, ***317:35-21-11***, ***317:35-21-12*** and ***317:35-21-14*** will add reference, within the Breast and Cervical Cancer (BCC) policy, to the American Society for Colposcopy and Cervical Pathology Consensus, and National Comprehensive Cancer Network, which provides guidelines for "in need of treatment" determinations. Additional revisions will clarify that creditable coverage is verified by the Oklahoma Health Care Authority eligibility coordinator and no longer the Centers for Disease Control screener. Further revisions will replace the term "OKDHS worker" with the term "eligibility coordinator", and "SoonerCare Medical Director" will be replaced with "Chief Medical Officer". Finally, revisions will update/remove outdated language in order to reflect current business practices and to provide consistency throughout policy.
Budget Impact: Budget neutral

(Reference APA WF # 18-19)

F. AMENDING agency rules at ***OAC 317:35-18-5*** will reflect current business practices pertaining specifically to where the Oklahoma Department of Human Services nurse or Programs of All-Inclusive Care for the Elderly (PACE) nurse are to perform the Uniform Comprehensive Assessment

Tool, Part III visit. Additionally, revisions will include cleanup and updating of obsolete acronyms.
Budget Impact: Budget neutral

(Reference APA WF # 18-20)

G. AMENDING agency rules at ***OAC 317:30-5-761*** and ***317:30-5-763*** will update spouse and legal guardian requirements as paid service providers for personal care services. Additional revisions will align current rules on how SoonerCare (Medicaid) funding is used for caregiver direct care support reimbursement and update assisted living rules regarding Home and Community-Based Service (HCBS) waivers for visitation in residential HCBS settings. Further revisions will ensure that policy aligns rules with the Centers for Medicare and Medicaid Services' restrictions in the assisted living facilities for overnight visits of member's guests. Finally, the proposed revisions will remove and update outdated policy in order to align with current business practices.
Budget Impact: Budget neutral

(Reference APA WF # 18-21A)

H. AMENDING agency rules at ***OAC 317:35-15-4***, ***317:35-15-10***, ***317:35-17-14***, ***317:35-17-22*** and ***317:35-19-2*** will remove outdated language regarding the Uniform Comprehensive Assessment Tool (UCAT) Part III submission and align it with the ADvantage eligibility policy. Additional revisions will add guidelines for the Oklahoma Department of Human Services (DHS) nurse when establishing/assigning a medical certification period with annual reviews for persons younger than eighteen (18) years of age. Further revisions will address personal care services medical eligibility extensions when medical redetermination is not made by the current medical certification end date; what constitutes reasons that personal care services may be terminated in a member's home and documentation that must be provided to justify termination. Other revisions will provide clarification on service provider's and service recipient's duties and responsibilities; reflect new federal regulations that affect the Electronic Visit Verification (EVV) process and implementation; and process changes for case management services. Finally, rules will add language to clarify existing policy procedure and practice in administering Consumer-Directed Personal Assistance Services and Supports (CD-PASS) service options.
Budget Impact: Budget neutral

(Reference APA WF # 18-21B)

I. AMENDING agency rules at ***OAC 317:30-3-40*** will add language to clarify that a member receives services based on current needs through the Home and Community-Based Service waivers. Additional revisions will eliminate and update outdated policy in order to better align with current business practices.
Budget Impact: Budget neutral

(Reference APA WF # 18-22A)

J. AMENDING agency rules at ***OAC 317:40-7-5***, ***317:40-7-6***, ***317:40-7-15*** and ***317:40-7-21*** will add new language to provide general clarification that when a home-based business is established through the Oklahoma Department of Rehabilitation services (OKDRS), Developmental Disabilities Services (DDS) stabilization services are utilized when the OKDRS end. In addition, new language will provide guidelines for the Personal Support Team to follow when the required thirty (30) hours of employment services (community-based services, center-based services, employment training specialist intensive training services, and job coaching services) through Home and Community-Based Service (HCBS) waivers is not met. Finally, the proposed revisions will include the removal of outdated language relating to the exception process for employment services through the HCBS waiver and update obsolete acronyms.
Budget Impact: Budget neutral

(Reference APA WF # 18-22B)

Item to be presented by Jill Ratterman, Clinical Pharmacist

6. Action Item – Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Oklahoma Statutes 5030.3.

   a) Consideration and vote to add **Jivi® [Antihemophilic Factor (Recombinant), PEGylated-aucl], Hemlibra® (Emicizumab-kxwh), Feiba® (Anti-Inhibitor Coagulant Complex), and NovoSeven® RT [Coagulation Factor VIIa (Recombinant)]** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Anthony Armstrong, Chairman

7. Discussion Item – Proposed Executive Session as Recommended by the Chief of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B)(1),(4) and (7).

   Discussion of Personnel Matters
   Discussion of Pending Contractual Litigation

8. New Business

9. ADJOURNMENT

NEXT BOARD MEETING
March 21, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULAR BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 10, 2019
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on January 9, 2018 at 11:30 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on January 7, 2019 at 1:19 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Armstrong called the meeting to order at 1:01 p.m.

BOARD MEMBERS PRESENT: Chairman Armstrong, Vice-Chairman Yaffe, Member Bryant, Member Case, Member Hupfeld (arrived at 1:57p.m.), Member McVay

BOARD MEMBERS ABSENT: Member Nuttle

OTHERS PRESENT:

Nicole Collins, OHCA
Breanna Russell, OHCA
Terri Kinder, OFN/MATF
Tewanna Edwards, OHCA
Tiffany Greene, DHS-DDS
Avis Hill, OHCA
Brent Wilburn, OKPCA
Kevin Kelley, OHCA
Katie Cummings, OHCA
Aaron Morris, OHCA
Anita Gaddis, OHCA
Jo Stainsby, OHCA
Brenda Teel, Chickasaw Nation
Monika Lutz, OHCA
Mike Herndon, OHCA
Joni Bruce, OFN
Kim Helton, OHCA
Christine Smith, OHCA
Kyle Janzen, OHCA
Sandra Puebla, OHCA

OTHERS PRESENT:

Mia Smith, OHCA
Shantice Atkins, OHCA
LeKenya Antwine, OHCA
Aimee Merick, OHCA
Dwyna Vick, OHCA
Tracy O'Shannon, OHCA
Terry McCurren, OTSUKA
David Ward, OHCA
Mike Fogarty
Tasha Black, OHCA
Tina Penrod, OHCA
Rep. Lewis Moore
Tyler Talley, eCapitol
Weston Glenn, OHCA
Will Widman, DXC
Melissa Abbott, PMC
Ashley Carlisle, OHCA
Katelynn Burns, OHCA
Melanie Lawrence, OHCA
Daryn Kirkpatrick, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULAR SCHEDULED BOARD MEETING HELD DECEMBER 13, 2018.

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 Case moved for approval of the December 13, 2018 board meeting minutes as published. The motion was seconded by Vice-Chairman Yaffe

FOR THE MOTION: Chairman Armstrong, Member Bryant, Member McVay

BOARD MEMBERS ABSENT: Member Hupfeld, Member Nuttle

ITEM 3A /EMPLOYEE RECOGNITION

Ms. Brown was not in attendance.

ITEM 3B / CERTIFIED HEALTHY BUSINESS
Katie Cummings, Civil Rights and Wellness Coordinator

Ms. Cummings gave a brief overview of what is required to be selected as a Certified Healthy Business. OHCA has been selected as a Certified Healthy Business for the last 10 years and this year was given the Excellence award. Ms. Cummings will attend the awards ceremony which will take place in March.

ITEM 3C / FINANCIAL UPDATE
Aaron Morris, Chief Financial Officer

Mr. Morris gave a brief update on OHCA's November financials. OHCA has a negative $1 million state dollars variance, less than 0.1% of our overall budget. OHCA has a positive variance in physician line, mostly from utilization. Nursing facilities had a flat budget for SFY19. In total, the agency program spending is under budget by $3.3 million state dollars and under budget in administrative spending by $2.3 million state dollars. OHCA continues to run under budget in drug rebates by $4.4 million state dollars and tobacco tax revenues by $3.1 million state dollar. OHCA is running over budget in medical refunds by $0.9 million state dollars. For more detailed information, see Item 3b in the board packet.

ITEM 3D / MEDICAID DIRECTOR'S UPDATE
Melody Anthony, Deputy State Medicaid Director

Ms. Anthony provided an update for October 2018 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program and total in-state providers. Ms. Anthony also presented charts showing monthly trend for providers, monthly enrollment and a monthly trend in enrollment for Choice, Traditional and Insure Oklahoma and trend for total members and how it relates to the unemployment rate. For more detailed information, see Item 3d in the board packet.

ITEM 3E / PHARMACY OVERVIEW
Burl Beasley, Pharmacy Director

Mr. Beasley gave a brief Pharmacy overview, which included information about staff and organization, drug claims, benefit trend, drug utilization review, pharmacy contracts and drug rebates. For more detailed information, see item 3e in the board packet.

ITEM 3E.i / VALUE BASED CONTRACTING
Kerri Wade, Pharmacy Operations Manager

Ms. Wade gave a brief overview of Value Based Contracting. For more detailed information, see item 3e in the board packet.

ITEM 3E.ii / REBATE PROCESS UPDATE
Stacy Hale, Drug Rebate Manager

Ms. Hale gave an update on Rebate Process, which included information about programs, supplemental rebate program, 340B, diabetic supplies. For more detailed information, see item 3e in the board packet.

ITEM 3F / MEDICAID MEMBER VIEWS
Joni Bruce, Oklahoma Family Network Executive Director and Terry Kinder, Member Advisory Task Force Member

Ms. Bruce introduced Ms. Kinder, who provided an update of her recent panel participation at the National Association of Medicaid Directors 2018 Fall Conference. For more detailed information, see item 3f in the board packet.

ITEM 4 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 5A-B / CONSIDERATION AND VOTE OF THE AUTHORITY FOR EXPENDITURE OF FUND
Kimberly Wilson, Procurement & Contracts Development Director

a) Consulting Services

MOTION: Member Case moved for approval of item 5a as published. The motion was seconded by Vice-Chairman Yaffe

FOR THE MOTION: Chairman Armstrong, Member Bryant, Member McVay

ABSTAINED: Member Hupfeld

BOARD MEMBERS ABSENT: Member Nuttle

b) Electronic Health Record Auditing Services

MOTION: Vice-Chairman Yaffe moved for approval of item 5b as published. The motion was seconded by Member Bryant

FOR THE MOTION: Chairman Armstrong, Member Case, Member Hupfeld, Member McVay

BOARD MEMBERS ABSENT: Member Nuttle

ITEM 6A-D / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUES 5030.3.
Burl Beasley, Assistant Director of Pharmacy Services

a) **Onpattro™ (Patisiran) and Tegsedi™ (Inotersen)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) **Zemdri™ (plazomicin vial for IV infusion), Xerava™ (eravacycline vial for IV infusion), Nuzyra™ (omadacycline tablet and vial for IV infusion), and Seysara™ (sarecycline tablet)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) **Signifor® LAR (Pasireotide)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) **Symdeko® (Tezacaftor/Ivacaftor)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member McVay moved for approval of Item 6a-d. The motion was seconded by Vice-Chairman Yaffe.

FOR THE MOTION: Chairman Armstrong, Member Bryant, Member Case, Member Hupfeld

BOARD MEMBERS ABSENT: Member Nuttle

ITEM 7 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4)
Nicole Nantois, Chief of Legal Services

There was no executive session.

ITEM 11 / NEW BUSINESS

There was no new business.

ITEM 12 / ADJOURNMENT

MOTION: Member Hupfeld moved for approval for adjournment. The motion was seconded by Member McVay.

FOR THE MOTION: Chairman Armstrong, Vice-Chairman Yaffe, Member Bryant, Member Case,

BOARD MEMBERS ABSENT: Member Nuttle

Meeting adjourned at 2:26 p.m., 1/10/2019

NEXT BOARD MEETING
February 14, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

FINANCIAL REPORT

For the Six Months Ended December 31, 2018
Submitted to the CEO & Board

- Revenues for OHCA through December, accounting for receivables, were **$2,124,898,682** or **.9% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,137,545,703** or **.9% under** budget.
- The state dollar budget variance through December is a positive **$356,849.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		.7
Administration		3.2
Revenues:		
Drug Rebate		(1.7)
Medical Refunds		1.3
Taxes and Fees		(3.2)
Total FY 18 Variance	**$**	**.3**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2019, For the Six Month Period Ending December 31, 2018

REVENUES	FY19 Budget YTD	FY19 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 516,920,928	$ 516,920,928	$ -	0.0%
State Appropriations - GME Appropriated Funds	$ 55,022,160	$ 55,022,160	$ -	0.0%
Federal Funds	1,189,355,635	1,174,347,236	(15,008,400)	(1.3)%
Tobacco Tax Collections	25,617,802	22,483,935	(3,133,867)	(12.2)%
Quality of Care Collections	39,605,640	39,285,397	(320,243)	(0.8)%
Prior Year Carryover	11,000,000	11,000,000	-	0.0%
Federal Deferral - Interest	129,111	129,111	-	0.0%
Drug Rebates	172,322,862	167,785,795	(4,537,067)	(2.6)%
Medical Refunds	17,496,114	20,895,702	3,399,587	19.4%
Supplemental Hospital Offset Payment Program	109,083,790	109,083,790	-	0.0%
Other Revenues	7,673,333	7,944,629	271,296	3.5%
TOTAL REVENUES	**$ 2,144,227,376**	**$ 2,124,898,682**	**$ (19,328,694)**	**(0.9)%**

EXPENDITURES	FY19 Budget YTD	FY19 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 29,245,608**	**$ 23,717,083**	**$ 5,528,525**	**18.9%**
ADMINISTRATION - CONTRACTS	**$ 52,972,702**	**$ 48,624,489**	**$ 4,348,213**	**8.2%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	19,427,973	19,418,169	9,804	0.1%
Acute Fee for Service Payments:				
Hospital Services	471,728,015	469,840,779	1,887,235	0.4%
Behavioral Health	9,737,511	9,048,680	688,831	7.1%
Physicians	204,960,535	192,780,628	12,179,907	5.9%
Dentists	64,410,591	65,834,752	(1,424,161)	(2.2)%
Other Practitioners	27,134,482	27,142,404	(7,922)	(0.0)%
Home Health Care	10,687,755	12,027,455	(1,339,700)	(12.5)%
Lab & Radiology	13,532,933	13,274,971	257,962	1.9%
Medical Supplies	26,163,688	26,892,877	(729,189)	(2.8)%
Ambulatory/Clinics	115,643,148	119,191,019	(3,547,871)	(3.1)%
Prescription Drugs	316,919,124	309,687,762	7,231,362	2.3%
OHCA Therapeutic Foster Care	83,214	527	82,687	0.0%
Other Payments:				
Nursing Facilities	275,873,295	282,017,638	(6,144,343)	(2.2)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	31,000,544	31,843,435	(842,891)	(2.7)%
Medicare Buy-In	87,381,331	87,055,432	325,899	0.4%
Transportation	35,399,101	34,575,489	823,613	2.3%
Money Follows the Person-OHCA	173,498	197,861	(24,363)	0.0%
Electonic Health Records-Incentive Payments	1,713,150	1,713,150	-	0.0%
Part D Phase-In Contribution	55,510,946	55,180,681	330,265	0.6%
Supplemental Hospital Offset Payment Program	246,991,778	246,991,778	-	0.0%
Telligen	5,473,470	5,431,508	41,962	0.8%
Total OHCA Medical Programs	**2,019,946,084**	**2,010,146,997**	**9,799,087**	**0.5%**
OHCA Non-Title XIX Medical Payments	44,691	34,974	9,717	0.0%
OHCA Non-Title XIX - GME	55,022,160	55,022,160	0	0.0%
TOTAL OHCA	**$ 2,157,231,245**	**$ 2,137,545,703**	**$ 19,685,542**	**0.9%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (13,003,869)**	**$ (12,647,020)**	**$ 356,849**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2019, For the Six Month Period Ending December 31, 2018

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 19,463,397	$ 19,413,128	$ -	$ 45,228	$ -	$ 5,041	$ -
Inpatient Acute Care	557,254,127	303,411,142	243,343	1,606,063	184,041,544	421,485	67,530,551
Outpatient Acute Care	222,906,591	162,981,246	20,802	2,355,915	54,785,867	2,762,761	-
Behavioral Health - Inpatient	21,264,861	5,034,340	-	215,447	7,262,639	-	8,752,435
Behavioral Health - Psychiatrist	4,916,068	4,014,340	-	-	901,728	-	-
Behavioral Health - Outpatient	7,857,929	-	-	-	-	-	7,857,929
Behaviorial Health-Health Home	22,856,073	-	-	-	-	-	22,856,073
Behavioral Health Facility- Rehab	119,861,017	-	-	-	-	51,352	119,861,017
Behavioral Health - Case Management	1,343,211	-	-	-	-	-	1,343,211
Behavioral Health - PRTF	30,560,404	-	-	-	-	-	30,560,404
Behavioral Health - CCBHC	25,169,152	-					25,169,152
Residential Behavioral Management	5,145,630	-	-	-	-	-	5,145,630
Targeted Case Management	35,507,282	-	-	-	-	-	35,507,282
Therapeutic Foster Care	527	527	-	-	-	-	-
Physicians	227,001,536	190,523,040	29,050	2,626,487	-	2,228,538	31,594,420
Dentists	65,857,259	65,830,480	-	22,507	-	4,272	-
Mid Level Practitioners	1,032,044	1,027,754	-	4,006	-	284	-
Other Practitioners	26,364,030	25,841,338	223,182	249,663	-	49,846	-
Home Health Care	12,035,890	12,024,522	-	8,434	-	2,934	-
Lab & Radiology	13,662,621	13,180,600	-	387,650	-	94,371	-
Medical Supplies	27,011,368	25,518,106	1,355,766	118,492	-	19,005	-
Clinic Services	120,811,552	116,086,649	-	831,445	-	124,398	3,769,061
Ambulatory Surgery Centers	3,063,774	2,973,129	-	83,801	-	6,844	-
Personal Care Services	5,338,132	-	-	-	-	-	5,338,132
Nursing Facilities	282,017,638	171,661,312	110,356,326	-	-	-	-
Transportation	34,550,228	33,166,366	1,262,741	51,623	-	69,498	-
IME/DME	36,678,762	-	-	-	-	-	36,678,762
ICF/IID Private	31,843,435	26,030,777	5,812,658	-	-	-	-
ICF/IID Public	8,884,848	-	-	-	-	-	8,884,848
CMS Payments	142,236,113	142,009,501	226,612	-	-	-	-
Prescription Drugs	316,380,361	308,427,190	-	6,692,599	-	1,260,573	-
Miscellaneous Medical Payments	76,883	71,941	-	-	-	4,943	-
Home and Community Based Waiver	103,559,749	-	-	-	-	-	103,559,749
Homeward Bound Waiver	39,579,037	-	-	-	-	-	39,579,037
Money Follows the Person	197,861	197,861	-	-	-	-	-
In-Home Support Waiver	12,153,253	-	-	-	-	-	12,153,253
ADvantage Waiver	70,890,159	-	-	-	-	-	70,890,159
Family Planning/Family Planning Waiver	2,126,286	-	-	-	-	-	2,126,286
Premium Assistance*	28,772,326	-	-	28,772,325.85	-	-	-
Telligen	5,431,508	5,431,508	-	-	-	-	-
Electronic Health Records Incentive Payments	1,713,150	1,713,150	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,693,376,077**	**$ -**	**$ 1,636,569,946**	**$ 119,530,481**	**$ 44,071,687**	**$ 246,991,778**	**$ 7,106,144**	**$ 639,157,393**

* Includes $28,546,000.37 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:

Other State Agencies

SFY 2019, For the Six Month Period Ending December 31, 2018

REVENUE		FY19 Actual YTD
Revenues from Other State Agencies	$	283,058,547
Federal Funds		398,144,680
TOTAL REVENUES	**$**	**681,203,227**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	103,559,749
Money Follows the Person		-
Homeward Bound Waiver		39,579,037
In-Home Support Waivers		12,153,253
ADvantage Waiver		70,890,159
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		8,884,848
Personal Care		5,338,132
Residential Behavioral Management		3,419,429
Targeted Case Management		31,238,145
Total Department of Human Services		**275,062,753**
State Employees Physician Payment		
Physician Payments		31,594,420
Total State Employees Physician Payment		**31,594,420**
Education Payments		
Indirect Medical Education		34,965,572
Direct Medical Education		1,713,190
Total Education Payments		**36,678,762**
Office of Juvenile Affairs		
Targeted Case Management		1,068,102
Residential Behavioral Management		1,726,201
Total Office of Juvenile Affairs		**2,794,304**
Department of Mental Health		
Case Management		1,343,211
Inpatient Psychiatric Free-standing		8,752,435
Outpatient		7,857,929
Health Homes		22,856,073
Psychiatric Residential Treatment Facility		30,560,404
Certified Community Behavioral Health Clinics		25,169,152
Rehabilitation Centers		119,861,017
Total Department of Mental Health		**216,400,222**
State Department of Health		
Children's First		341,800
Sooner Start		1,066,900
Early Intervention		2,093,406
Early and Periodic Screening, Diagnosis, and Treatment Clinic		945,073
Family Planning		158,599
Family Planning Waiver		1,961,197
Maternity Clinic		964
Total Department of Health		**6,567,940**
County Health Departments		
EPSDT Clinic		306,775
Family Planning Waiver		6,489
Total County Health Departments		**313,264**
State Department of Education		**80,640**
Public Schools		**685,189**
Medicare DRG Limit		**60,000,000**
Native American Tribal Agreements		**1,449,349**
Department of Corrections		**1,154,687**
JD McCarty		**6,375,864**
Total OSA Medicaid Programs	**$**	**639,157,393**
OSA Non-Medicaid Programs	**$**	**40,655,235**
Accounts Receivable from OSA	**$**	**(1,390,598)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2019, For the Six Month Period Ending December 31, 2018

REVENUES		FY 19 Revenue
SHOPP Assessment Fee		108,991,771
Federal Draws	$	149,714,534
Interest		89,737
Penalties		2,283
State Appropriations		(15,100,000)
TOTAL REVENUES	$	243,698,324

EXPENDITURES	Quarter 7/1/18 - 9/30/18	Quarter 10/1/18 - 12/31/18	Quarter 1/1/19 - 3/31/19	Quarter 4/1/19 - 6/30/19		FY 19 Expenditures
Program Costs:						
Hospital - Inpatient Care	84,988,728	99,052,816			$	184,041,544
Hospital -Outpatient Care	25,649,937	29,135,930				54,785,867
Psychiatric Facilities-Inpatient	3,352,856	3,909,783				7,262,639
Rehabilitation Facilities-Inpatient	416,290	485,439				901,728
Total OHCA Program Costs	114,407,810	132,583,968	-	-	$	246,991,778
Total Expenditures					$	246,991,778
CASH BALANCE					$	(3,293,454)

*** Expenditures and Federal Revenue processed through Fund 340

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OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

SFY 2019, For the Six Month Period Ending December 31, 2018

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 39,265,724	$ 39,265,724
Interest Earned	19,672	19,672
TOTAL REVENUES	**$ 39,285,397**	**$ 39,285,397**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 108,522,349	$ 42,868,622	
Eyeglasses and Dentures	136,477	53,925	
Personal Allowance Increase	1,697,500	670,745	
Coverage for Durable Medical Equipment and Supplies	1,355,766	535,867	
Coverage of Qualified Medicare Beneficiary	516,378	204,098	
Part D Phase-In	226,612	226,612	
ICF/IID Rate Adjustment	2,676,965	1,057,721	
Acute Services ICF/IID	3,135,692	1,237,818	
Non-emergency Transportation - Soonerride	1,262,741	498,984	
Total Program Costs	**$ 119,530,481**	**$ 47,354,392**	**$ 47,354,392**
Administration			
OHCA Administration Costs	$ 271,484	$ 135,742	
DHS-Ombudsmen	27,092	27,092	
OSDH-Nursing Facility Inspectors	35,001	35,001	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 333,577**	**$ 197,835**	**$ 197,835**
Total Quality of Care Fee Costs	**$ 119,864,058**	**$ 47,552,227**	
TOTAL STATE SHARE OF COSTS			**$ 47,552,227**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2019, For the Six Month Period Ending December 31, 2018

REVENUES	FY 18 Carryover	FY 19 Revenue	Total Revenue
Prior Year Balance	$ 12,902,064	$ -	$ 6,997,587
State Appropriations	(6,000,000)	-	-
Tobacco Tax Collections	-	18,492,112	18,492,112
Interest Income	-	122,203	122,203
Federal Draws	208,931	17,979,746	17,979,746
TOTAL REVENUES	$ 7,110,995	$ 36,594,062	$ 43,591,648

EXPENDITURES		FY 18 Expenditures	FY 19 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 28,546,000	$ 28,546,000
	College Students/ESI Dental		226,325	89,543
Individual Plan				
	SoonerCare Choice		$ 43,971	$ 17,383
	Inpatient Hospital		1,602,807	635,368
	Outpatient Hospital		2,288,756	911,135
	BH - Inpatient Services-DRG		203,938	80,181
	BH -Psychiatrist		-	-
	Physicians		2,594,599	1,028,162
	Dentists		22,048	8,594
	Mid Level Practitioner		3,810	1,512
	Other Practitioners		246,996	97,855
	Home Health		8,434	3,365
	Lab and Radiology		381,045	150,312
	Medical Supplies		117,974	46,737
	Clinic Services		803,708	317,526
	Ambulatory Surgery Center		83,801	33,418
	Prescription Drugs		6,515,954	2,567,481
	Transportation		50,917	20,060
	Premiums Collected		-	(274,975)
Total Individual Plan			$ 14,968,761	$ 5,644,116
	College Students-Service Costs		$ 330,601	$ 129,688
Total OHCA Program Costs			$ 44,071,687	$ 34,409,348
Administrative Costs				
	Salaries	$ 24,543	$ 1,133,894	$ 1,158,437
	Operating Costs	9,662	57,389	67,051
	Health Dept-Postponing	-	-	-
	Contract - HP	79,204	401,210	480,414
Total Administrative Costs		$ 113,409	$ 1,592,494	$ 1,705,903
Total Expenditures				$ 36,115,251
NET CASH BALANCE		$ 6,997,587		$ 7,476,397

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2019, For the Six Month Period Ending December 31, 2018

REVENUES	FY 19 Revenue	State Share
Tobacco Tax Collections	$ 369,085	$ 369,085
TOTAL REVENUES	**$ 369,085**	**$ 369,085**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,041	$ 1,391	
Inpatient Hospital	421,485	114,486	
Outpatient Hospital	2,762,761	761,639	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	2,228,538	621,902	
Dentists	4,272	1,182	
Mid-level Practitioner	284	78	
Other Practitioners	49,846	13,740	
Home Health	2,934	809	
Lab & Radiology	94,371	26,080	
Medical Supplies	19,005	5,163	
Clinic Services	124,398	34,536	
Ambulatory Surgery Center	6,844	1,836	
Prescription Drugs	1,260,573	348,723	
Transportation	69,498	19,266	
Miscellaneous Medical	4,943	1,313	
Total OHCA Program Costs	**$ 7,054,792**	**$ 1,952,144**	
OSA DMHSAS Rehab	$ 51,352	14,159	
Total Medicaid Program Costs	**$ 7,106,144**	**$ 1,966,303**	
TOTAL STATE SHARE OF COSTS			**$ 1,966,303**

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.

OHCA Board Meeting
February 14, 2019
(December 2018 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment December 2018	Children December 2018	Adults December 2018	Enrollment Change	Total Expenditures December	PMPM December 2018
SoonerCare Choice Patient-Centered Medical Home			**529,789**	**440,288**	**89,501**	**-4,150**	**$151,887,311**	
	Lower Cost	*(Children/Parents; Other)*	487,182	427,116	60,066	-4,020	$109,546,248	$225
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	42,607	13,172	29,435	-130	$42,341,063	$994
SoonerCare Traditional			**231,828**	**84,052**	**147,776**	**-720**	**$172,916,012**	
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	116,358	79,354	37,004	-748	$39,902,576	$343
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	115,470	4,698	110,772	28	$133,013,436	$1,152
Insure Oklahoma			**18,654**	**529**	**18,125**	**-218**	**$6,833,126**	
	Employer-Sponsored Insurance		13,632	327	13,305	-79	$4,378,460	$321
	Individual Plan		5,022	202	4,820	-139	$2,454,666	$489
SoonerPlan			**29,115**	**2,351**	**26,764**	**-917**	**$233,036**	$8
TOTAL			**809,386**	**527,220**	**282,166**	**-6,005**	**$331,869,485**	

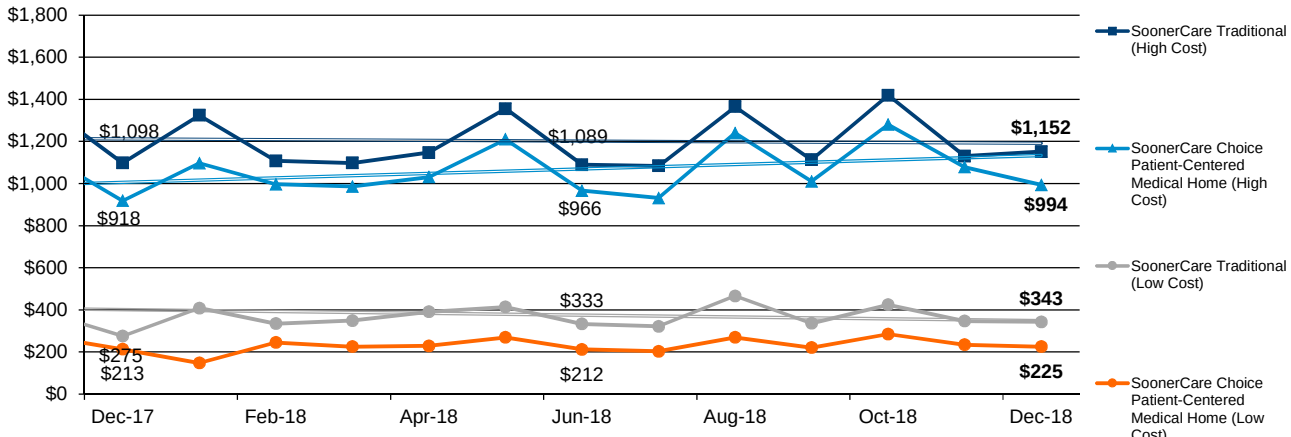
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

Total In-State Providers: 33,604 (+146) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

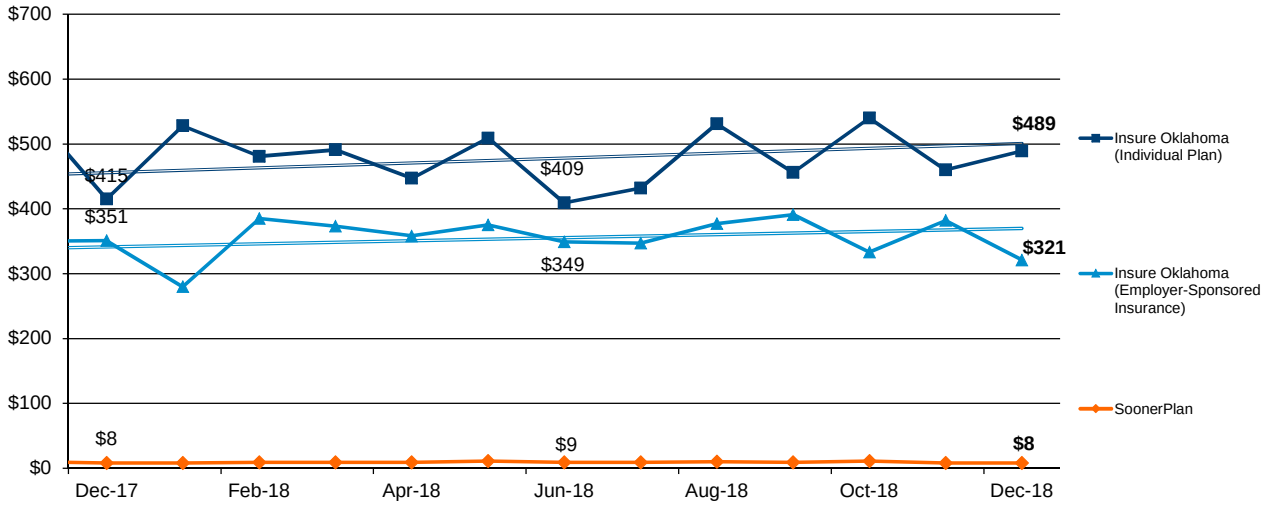
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs*	PCMH
9,877	890	1,127	161	4,719	637	411	7,111	2,591

*PCPs consist of all providers contracted as a Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant.

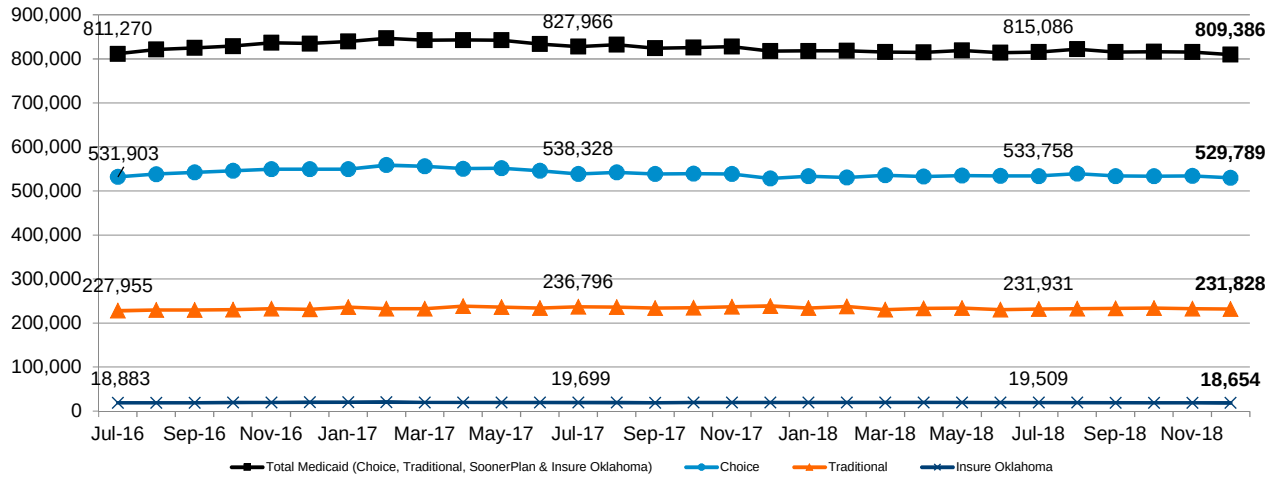
PER MEMBER PER MONTH COST BY GROUP

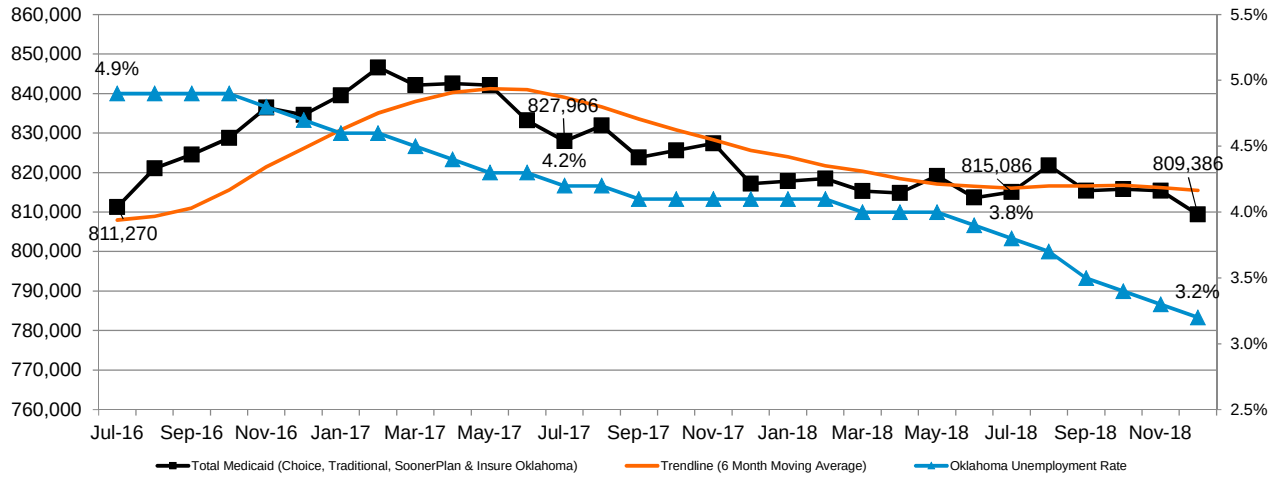


Low Cost includes members qualified under Children/Parents (TANF) and Other; High Cost members qualify under Aged, Blind or Disabled, Oklahoma Cares, TEFRA or a Home and Community-Based Services waiver.



ENROLLMENT BY MONTH





Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted. Data was extracted on 9/26/2018.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds.

OHCA Medical Professional Services

Medical / Dental Directors Section

- 4 Full time Physicians / 1 Full time Dentist
  - 1 Chief Medical Officer
  - 1 Sr. Medical Director
  - 2 Medical Directors
  - 1 Dental Director
  - 1 Geneticist
- Consultants
  - 1 Allergy / Pediatrics
  - 1 OB / GYN
  - 1 Optometrist
  - 1 Family Practice
  - 1 Audiologist
  - 1 Podiatrist
  - 1 Orthodontist
  - 2 Dentists

Medical Authorization and Review Section

- Prior Authorization Review
  - 9 Full time nurses / 6 Full time Analysts
    - 1 Director
    - 2 Supervisors
    - 1 Sr. Medical Review Nurse
    - 5 Medical Reviews Nurses
    - 6 Medical Auth Analysts
    - Consultants:
      - 5 PT (with 1 handling DME)
      - 4 SLP Therapists
      - 1 OT
      - 5 Contract Nurses
- Systems Integrity / Suspended claims Review
  - 10 Full time Nurses / 1 Full time Medical Data Analyst / 1 Full time Coding Analyst

Quality Assurance / Quality Improvement Section

- 4 Full time Nurses / 2 Full time Analysts / 1 Full time Coordinator
  - 1 Manager
  - 3 Nurse Case Managers
  - 2 Compliance Analysts
  - 1 QA/QI Coordinator

Medical Administrative Support Services Section

- 5 Full time Nurses / 1 Full time Lead / 1 Full time Analyst
  - 1 Director
  - 4 Medical Administrative Nurses
  - 1 Medical Administrative Lead
  - 1 Medical Data Analyst

Medical / Dental Directors Section

1. Prior authorization for Medical and Dental reviews
2. Medical reviews of complaints related to quality of care
3. Program Integrity (PI) Initial review support and audit reconsideration reviews
4. Coverage research and decision making, procedures, new initiatives, and policy input
5. Misc reviews - BCC, C-sections, Out of State, etc
6. Legal appeal hearings
7. Guideline development support and review
8. Peer-to-peer consultations
9. Medical/Dental expertise and resource for agency

Medical Authorization and Review Section

1. Timely review of PAs to determine medical necessity
   a. Total Lines - 423,099 (2018)
   b. Amendments - 39,673
2. Systems Integrity (SI) retrospective review of claims for medical necessity and coding appropriateness
   a. 153,457 Claim lines reviewed
3. Calls and E-mails - 14,258

Quality Assurance / Quality Improvement Section

1. Receive and review quality of care referrals
2. Member complaints
3. Provider issues - complex issues research to resolution
4. QIO - Quality Improvement Organization Contract Mgmt
   a. External Peer Review - currently 21 cases in progress
   b. Retrospective Hospital Reviews - 1600 claims/mo
5. CAHPS Survey - Consumer Assessment of Healthcare Providers and Systems and PAM - Payment Accuracy Measurement (Annual)
6. QAAG - Quality Assurance Advisory Group
7. State Licensure Action - Review and monitoring
8. PCMH (Patient Centered Medical Home) - Compliance Reviews
   a. 179 in 2018

Medical Administrative Support Services Section

1. Guideline Research and Development
2. Evidence Based Research for coverage determination of new product and technology
   Examples: a. Biologic skin substitutes
   b. Trans Catheter Aortic Valve Replacement
3. Utilization Review - Looking at outliers and areas of rapid utilization increase - Example: Urine Drug Testing - 2011 - $3.7 M / 2014 - $32 M / 2016-18 - $6 M
4. ICD-10, CPT, and HCPCS code review for coverage
5. Coding expertise and resource for agency
6. New project Research & Development - Example: Interqual automation implementation into MAU
7. Policy input and support
8. MPSU - Workflow analysis and reporting - Daily and Monthly

Oklahoma HealthCare Authority

Hemophilia

February 14, 2019

Jill Ratterman, D.Ph.
Carolyn Reconnu-Shoffner, RN, BSN, CCM

Hemophilia Overview

- What is Hemophilia?
  - Genetic disorder
  - Types
  - Severity
  - Complications
- Treatment
  - Comprehensive hemophilia treatment centers (HTCs)
  - Replace missing clotting factor
  - Protocols
  - Future

Hemophilia Overview, *cont.*

- OHCA management
  - Pharmacy
    - Pharmacy provider standards of care
    - Prior authorization
      - Right Patient, Right Product
      - Complications
      - State fiscal year 2018
  - Population Care Management (PCM)

Population Care Management

- PCM serves 12K members per year
- Nurse care Managers and Social Service Coordinators
- Wide scope of services

- High-risk obstetrics
- Pediatrics/Private duty nursing
- Breast/Cervical cancer
- Care coordination for distant services (in-state and out-of-state)
- Long-term care
- Hep C, Bariatrics, Hemophilia

Care Management for Members with Hemophilia

- Identification via claims
  - Unplanned/Unpredictable care experiences (3 or > Emergency Dept. visits per year) OR
  - Cost/Utilization ($50K annually)
  - Outreach to assess care management needs
- Referrals from OK Center for Bleeding and Clotting Disorders (OCBCD)
  - Situations in which extra support is needed (no-shows, custody, inconsistent use of prophylaxis, frequent injuries/ER)
  - Quarterly staffings with OCBCD

Care Management for Members with Hemophilia, *cont.*

- 40 members per year in PCM.
  - Health Access Networks follow an additional 12-15 members
- School-aged to adults
- Average age is 16
- 80% male
- 60% are aged 6 to 19
- 40-45% are aged, blind or disabled (ABD)
- Average duration in care mgmt. is 18 months; 40% greater than 2 years

Care Management for Members with Hemophilia, *cont.*

- Requires parent consent for minors, participation is voluntary
- Motivational interviewing principles for education and support
- Consideration given to literacy and health literacy
- Importance of provider relationship/tools to track status such as bleeding log; prophylaxis versus treatment; support groups/resources for social determinants of health

Care Management for Members with Hemophilia, *cont.*

- Consideration of developmental stages as they advance from young school-age through adolescence to teenage years and into adulthood
- Increased freedom/activity = increased risk
- Behavioral health screenings and referrals

Questions?

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

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

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

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

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

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

(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1 - 49 cents is rounded down, and 50 - 99 cents is rounded up). For example, an individual's weekly earnings of $99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ($99.90 x 4.3 = $429.57 rounds to $430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify ~~OASDI~~Retirement, Survivors, and Disability Insurance (RSDI) benefits.

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

(1) The value of Supplemental Nutrition Assistance Program (food stamps) received;
(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;
(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:
(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.
(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.
(C) Proceeds of a loan secured by an exempt asset are not an asset;
(5) One-third of child support payments received on behalf of the disabled minor child;
(6) Indian payments (including judgment funds or funds held in trust) distributed by the Secretary of the Interior ~~(BIA)~~(Bureau of Indian Affairs) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;
(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;
(8) Title III benefits from State and Community Programs on Aging;
(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired

Executives (SCORE) and Active Corps of Executives (ACE);
(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;
(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;
(13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;
(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;
(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments, or utilities;
(18) ~~LIHEAP~~Low Income Home Energy Assistance Program (LIHEAP) payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;
(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments, and disaster assistance organizations;
(22) Income of a sponsor to the sponsored eligible alien;
(23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The

Social Security Administration (SSA) approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of ~~18~~eighteen (18) months. The plan may be extended for an additional ~~18~~eighteen (18) months if needed, and an additional ~~12~~twelve (12) months (total ~~48~~forty- eight (48) months) when the objective involves a lengthy educational or training program;
(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);
(25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;
(26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;
(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);
(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);
(30) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009;
(31) Wages paid by the Census Bureau for temporary employment related to Census activities;
(32) Income tax refunds;
(33) Home energy assistance;
(34) Food or shelter based on need provided by nonprofit agencies;
(35) Money someone else spends to pay your expenses for items other than food or shelter (e.g., someone pays for your telephone or medical bills);
(36) Earned income for working students younger than ~~22~~twenty-two (22) years of age when they regularly attend a school, college, university or a course of vocational or technical training. Refer to Appendix C-1, Schedule VIII.E; Maximum Income, Resource and Payment Standards for the maximum monthly and yearly exclusion amounts;
(37) The cost of impairment-related work expenses for items or services that a disabled person needs in order to work; and

(38) The first $2,000 of compensation received per calendar year for participating in certain clinical trials.

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

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

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

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

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

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

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

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

(III) by using BENDEX and SDX.

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

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical

expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

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

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

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

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

(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for ~~the mentally retarded~~individuals with an intellectual disability or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three (3) months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) **Lump sum payments.**

(i) Any income received in a lump sum (with the exception of SSI and Retirement, Survivors, and Disability Insurance (RSDI) lump sum) covering a period of more than one (1) month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, ~~including~~excluding RSDI and SSI (with the exception of dedicated bank accounts for disabled/blind children under age ~~18~~eighteen (18)), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, ~~retroactive OASDI,~~ VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) OASDI and SSI retroactive payments do not count as income in the month of receipt. Any unspent portion of retroactive SSI and RSDI benefits is excluded from resources for nine (9) calendar months following the month of receipt. However, unspent money from a retroactive payment must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds, but if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount will count toward the resource limit. Refer to 20 Code of Federal Regulations (CFR) § 416.1233.

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

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

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

(D) **Income from capital resources and rental property.** Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights or interest.

(i) If royalty income is received monthly but in irregular

amounts, an average based on the previous six (6) months' royalty income is computed and used to determine income eligibility. When the difference between the gross and net income represents a production or severance tax (e.g., most oil royalties are reduced by this tax), the OHCA only uses the net figure when determining income eligibility. The production or severance tax is the cost of producing the income, and, therefore, is deducted from the gross income. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two (2) months' royalty income is averaged to compute countable monthly income.

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

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

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

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

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

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

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

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

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

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

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

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

(F) **Infrequent or irregular income.**

(i) Income is considered to be infrequent if the individual receives it only once during a calendar quarter from a single source and the individual did not

receive that type of income in the month preceding or following the month the income was received.

(ii) Income is considered to be irregular if the individual cannot reasonably expect to receive it.

(iii) OHCA excludes the following amount of infrequent or irregular income:

(I) the first $30 per calendar quarter of earned income; and

(II) the first $60 per calendar quarter of unearned income.

(iv) Infrequent or irregular income, whether earned or unearned, that exceeds these amounts is considered countable income in the month it is received.

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two (2) months' income, if possible, to determine income eligibility. Less than two (2) months' income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

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

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

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

(iv) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.

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

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

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

(d) **Computation of income.**

(1) **Earned income or unearned income.** The general income exclusion of $20 per month is allowed for earned or unearned income, unless the unearned income is SSP, on the combined income of the eligible individual and eligible or ineligible spouse. See paragraph (5) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income. The total

gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered.

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

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

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

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

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

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

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

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

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

(6) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount

of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three (3) broad categories:

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC SERVICES

317:30-5-95.1. Medical necessity criteria and coverage for adults aged twenty-one (21) to sixty-four (64)

(a) **Coverage for adults**. Coverage for adults aged twenty-one (21) to sixty-four (64) is limited to services in a psychiatric unit of a general hospital (see ~~OAC~~ Oklahoma Administrative Code (OAC) 317:30-5-95). Inpatient psychiatric services must be prior authorized in accordance with OAC 317:30-5-41.1. OHCA rules that apply to inpatient psychiatric coverage for adults aged twenty-one (21) to sixty-four (64) are found in Sections OAC 317:30-5-95.1 through 317:30-5-95.10.

(b) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for psychiatric disorders**. An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) that is attributable to a psychiatric disorder must meet the terms or conditions contained in (1), (2), (3), (4), one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) A primary diagnosis from the most recent edition of ~~"The Diagnostic and Statistical Manual of Mental Disorders"~~the Diagnostic and Statistical Manual of Mental Disorders (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses). Adjustment or substance related disorder may be a secondary diagnosis.

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a less intensive treatment program.

(4) Adult must be medically stable.

(5) Within the past forty-eight (48) hours, the behaviors present an imminent life-threatening emergency such as evidenced by:

(A) Specifically described suicide attempts, suicidal intent, or serious threat by the patient.

(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

(6) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

(C) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

(c) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for inpatient chemical dependency detoxification.** An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) for chemical dependency/ substance use/ detoxification must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.

(1) Any psychoactive substance dependency disorder described in the most recent edition of ~~"The Diagnostic and Statistical Manual of Mental Disorders"~~the Diagnostic and Statistical Manual of Mental Disorders (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses).

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a less intensive treatment program.

(4) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Need for active and aggressive pharmacological interventions.

(B) Need for stabilization of acute psychiatric symptoms.

(C) Need extensive treatment under physician direction.

(D) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

317:30-5-95.34. Active treatment for children

(a) The following words and terms, when used in this ~~section~~Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Discharge/~~Transition Planning~~transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, family and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(2) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential ~~(ROPES)~~(e.g. ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(3) **"Family therapy"** means interaction between ~~an LBHP~~a licensed behavioral health providers (LBHP) or licensure candidate, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(4) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).

(5) **"Individual rehabilitative treatment"** means a ~~face to face, one on one~~face-to-face, one-on-one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform ~~activities of daily living~~ ADL.

(6) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using ~~face to face, one on one~~face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(7) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate as defined in OAC 317:30-5-240.3, and two (2) or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "~~Active Treatment~~"active treatment." Active ~~Treatment~~treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of ~~18 up to 21~~eighteen (18) up to twenty-one (21), it is understood that family members and guardians will not always be involved in the member's treatment. Active ~~Treatment~~treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. ~~Evidence based~~Evidence-based practices such as trauma informed methodology should be utilized to minimize the use of ~~seclusion and restraint~~restraint and seclusion.

(c) For individuals age ~~18 up to 21~~eighteen (18) up to twenty-one (21), the ~~Active Treatment~~active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided ~~face-to-face~~face to face. Services, including type and frequency, will be specified in the ~~Individual Plan of Care~~individual plan of care.

(d) For individuals under age ~~18~~eighteen (18), the components of ~~Active Treatment~~active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. Individuals in Community Based

Transitional (CBT) treatment must receive ten (10) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty (60) minutes is the expectation to equal one (1) hour of treatment. When appropriate to meet the needs of the child, the ~~60~~sixty (60) minute timeframe may be split into sessions of no less than ~~15~~fifteen (15) minutes each on the condition that the ~~Active Treatment~~active treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for ~~Active Treatment~~active treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core Services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three (3) times per week for acute care and one (1) time a week in ~~Residential Treatment Facilities~~PRTFs. Individual treatment provided by the physician will never exceed ten (10) calendar days between sessions in PRTFs, never exceed seven (7) calendar days in a specialty PRTF and never exceed ~~30~~thirty (30) calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in acute care and one (1) hour per week in residential treatment by an LBHP or licensure candidate as described in OAC 317:30-5-240.3. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week for acute care and residential. One (1) hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate as described in OAC 317:30-5-240.3.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in acute care and two (2) hours per week in residential treatment by an LBHP or licensure candidate as defined in OAC 317:30-5-240.3. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy provided by an LBHP, licensure candidate, or ~~Licensed Therapeutic Recreation Specialist~~licensed therapeutic recreation specialist may be substituted.

(E) **Transition/~~Discharge Planning~~discharge planning.** Transition/discharge planning must be provided one (1) hour per week in acute care and thirty (30) minutes per week in residential and CBT. Transition/~~Discharge~~discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant ~~Bachelor's~~bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the

definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care.

(C) **Individual rehabilitative treatment.** Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the member's diagnosis.

(D) **Recreation therapy.** Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a ~~Licensed Therapeutic Recreation Specialist~~licensed therapeutic recreation specialist.

(E) **Occupational therapy.** Services will be provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor and postural development. Services include therapeutic goal-directing activities and/or exercises used to improve mobility and ~~activities of daily living (ADL)~~ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which they practice.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that

promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise groups, and individual physical wellness plan development, implementation assistance and support.

(3) **Modifications to active treatment.** When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

(e) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in ~~Acute~~acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in ~~RTC~~a residential treatment center (RTC), PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components may include assessments/evaluations to serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In acute, by day two (2), ~~1~~one (1) visit is required. By day ~~4, 2~~four (4), two (2) visits are required. By day ~~7, 3~~seven (7), three (3) visits are required.

(B) In RTC, PRTF or CBT, one (1) visit during admission week is required. In RTCs, ~~1~~one (1) visit during the admission week is required, then once a week thereafter. In PRTFs, one (1) visit during the admission week is required, then once a week thereafter. In CBT, ~~1~~one (1) visit is required within ~~7~~seven (7) days of admission. Individual treatment provided by the physician will never exceed ~~10~~ten (10) days between sessions in PRTFs, never exceed ~~7~~seven (7) days in a specialty PRTF and never exceed ~~30~~thirty (30) days in CBTs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a ~~History and Physical~~history and physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day

of the admission week, then the member must be seen by a physician within ~~24~~sixty (60) hours of admission time.

(2) **Individual therapy.**

(A) In acute, by day ~~3, 30~~three (3), thirty (30) minutes of treatment are required. By day ~~5, 1~~five (5), one (1) hour of treatment is required. Beginning on day ~~7, 2~~seven (7), two (2) hours of treatment are required each week. This does not include admission assessments/evaluations or ~~Psychosocial Evaluations~~psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In residential treatment (including PRTF and CBT), by day ~~6, 30~~six (6), thirty (30) minutes of treatment must be documented. Beginning on day ~~7, 1~~seven (7), one (1) hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ~~10~~ten (10) days between sessions. This does not include admission assessment/~~-~~evaluation or ~~Psychosocial Evaluations~~psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In acute, by day ~~6, 30~~six (6), thirty (30) minutes of treatment must be documented. Beginning on day ~~7, 1~~seven (7), one (1) hour of treatment is required each week. This does not include admission assessments/evaluation or ~~Psychosocial Evaluations~~psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or ~~Psychosocial Evaluation~~psychosocial evaluation has not been used to substitute the initial individual therapy requirement.

(B) In residential treatment (including PRTF and CBT), by day ~~6, 30~~six (6), thirty (30) minutes of treatment must be documented. Beginning on day ~~7, 1~~seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or ~~Psychosocial Evaluations~~psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or ~~Psychosocial Evaluation~~psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ~~10~~ten (10) days in between sessions.

(4) **Process group therapy.**

(A) In acute, by day ~~3, 1~~three (3), one (1) hour of treatment is required. By day ~~5, 2~~five (5), two (2) hours of treatment

are required. Beginning on day ~~7, 3~~seven (7), three (3) hours of treatment are required each week.

(B) In residential treatment (including PRTF and CBT), by day ~~5, 1~~five (5), one (1) hour of treatment is required. Beginning on day ~~7, 2~~seven (7), two (2) hours of treatment are required each week.

(f) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff ~~(RN/LPN)~~ (registered nurse (RN)/licensed practical nurse (LPN)), documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-28. Oklahoma Electronic Health Records Incentive Program

(a) **Program.** The Oklahoma Electronic Health Records (EHR) Incentive Program is authorized by the American Recovery and Reinvestment Act of 2009. Under this program, SoonerCare providers may qualify for incentive payments if they meet the eligibility guidelines in this section and demonstrate they are engaged in efforts to adopt, implement, upgrade, or meaningfully use certified ~~electronic health records (EHR)~~EHR technology. The Oklahoma EHR ~~incentive program~~Incentive Program is governed by the policy in this section and the Electronic Health Records Program Final Rule issued by the ~~CMS~~Center for Medicare and Medicaid Services (CMS) in CMS-0033-F and ~~45 CFR 170~~Section 170 of Title 45 of the Code of Federal Regulations (C.F.R.). Providers should also use the EHR program manual as a reference for additional program details.

(b) **Eligible providers.** To qualify for incentive payments, a provider must be an "eligible professional" or an "eligible hospital." Providers who receive incentive payments must have an existing Provider Agreement with the ~~OHCA~~Oklahoma Health Care Authority (OHCA).

(1) **Eligible professionals.** An eligible professional is defined as a physician, a physician assistant practicing in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) led by a physician assistant, a board certified pediatrician, a nurse practitioner, a certified nurse midwife, or a dentist. OHCA will determine eligibility based on the provider type, specialty associated with the provider in the ~~MMIS system~~Medicaid Management Information System, and documentation.

(A) Eligible professionals may not be hospital-based, unless they practice predominantly at an FQHC or RHC as defined by the CMS ~~Final Rule~~final rule. A "hospital-based" professional furnishes ninety percent (90%) or more of their SoonerCare-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or Emergency Room, through the use of the facilities and equipment of the hospital. Specific exclusions to the "hospital-based" definition may be allowed by federal law and are detailed in the Oklahoma EHR Incentive Program provider manual.

(B) Eligible professionals may not participate in both the Medicaid and Medicare EHR incentive payment program during the same payment year.

(2) **Eligible hospitals.** Eligible hospitals are ~~Children's Hospitals~~children's hospitals or ~~Acute Care Hospitals~~acute care hospitals, including ~~Critical Access Hospitals~~critical access hospitals and cancer hospitals. An ~~Acute Care Hospital~~acute care hospital is defined as a health care facility where the average length of patient stay is twenty-five (25) days or fewer and that has a CMS certification number that has the last four (4) digits in the series 0001-0879 and 1300-1399. A ~~Children's Hospital~~children's hospital is defined as a separately certified children's hospital, either freestanding or hospital-within-hospital, that predominantly treats individuals under ~~21~~twenty-one (21) years of age and has a CMS certification number with the last ~~4~~four (4) digits in the series 3300-3399 or, if it does not have a CMS certification number, has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR ~~incentive program~~Incentive Program. Hospitals that do not meet either of the preceding definitions are not eligible for incentive payments.

(c) **Patient volume.** Eligible professionals and eligible hospitals must meet SoonerCare patient volume criteria to qualify for incentive payments. Patient volume criteria compliance will be verified by the OHCA through claims data and provider audits. When calculating SoonerCare patient volume, all SoonerCare populations may be counted. To calculate patient volume, the provider's total SoonerCare patient encounters in the specified reporting period must be divided by the provider's total patient encounters in the same reporting period.

(1) **Eligible professionals**. Eligible professionals must meet a ~~30%~~thirty percent (30%) SoonerCare patient volume threshold over a continuous ~~90-day~~ninety-day (90-day) period in the preceding calendar year or the preceding ~~12 month~~twelve-month (12-month) period from the date of attestation. The only exception is for pediatricians, as discussed in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-28(c)(5).

(2) **Eligible hospitals.** With the exception of children's hospitals, which have no patient volume requirement, eligible hospitals must meet a ~~10%~~ten percent (10%) SoonerCare patient volume threshold over a continuous ~~90-day~~ninety-day (90-day) period in the preceding ~~calendar year~~federal fiscal year or over the ~~most recent continuous 12 month period~~preceding twelve-month (12-month) period from the date of attestation for which data are available prior to the payment year.

(3) **FQHC or RHC patient volume.** Eligible professionals practicing predominantly in ~~an~~a FQHC or RHC may be evaluated

according to their "needy individual" patient volume. To qualify as a "needy individual," patients must meet one (1) of the following criteria:

(A) Received medical assistance from SoonerCare;

(B) Were furnished uncompensated care by the provider; or

(C) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

(4) **Clinics and group practices.** Clinics or group practices may calculate patient volume using the clinic's or group's SoonerCare patient volume under the following conditions:

(A) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the eligible professional;

(B) There is an auditable data source to support the patient volume determination;

(C) All eligible professionals in the clinic or group practice use the same methodology for the payment year;

(D) The clinic or group practice uses the entire practice's patient volume and does not limit patient volume in any way; and

(E) If an eligible professional works inside and outside of the clinic or practice, the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the eligible professional's outside encounters.

(5) **Pediatricians.** Pediatricians may qualify for 2/3 incentive payments if their SoonerCare patient volume is ~~20-29%~~twenty to twenty-nine percent (20-29%). A pediatrician is defined as a medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children and possesses a valid, unrestricted medical license and board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP). To qualify as a pediatrician for the purpose of receiving a 2/3 payment under the incentive program, the provider must provide OHCA with a copy of their pediatric licenses and board certification.

(6) ~~**Out of state patients**~~**Out-of-state patients.** For eligible professionals and eligible hospitals using ~~out of state~~out-of-state Medicaid recipients for patient volume requirement purposes, the provider must retain proof of the encounter for the ~~out of state~~out-of-state patient.

(d) **Attestation.** Eligible professionals and eligible hospitals must execute an amendment to their SoonerCare Provider Agreement to attest to meeting program criteria through the Electronic Provider Enrollment (EPE) system in order to qualify for incentive

payments. Registration in the CMS EHR Incentive Payment Registration and Attestation system is a pre-requisite to EPE attestation. All required/supporting documentation, additional documentation requests, and/or attestation corrections must be submitted or completed within thirty (30) days of notification to avoid denial of the EHR attestation.

(e) **Adoption/ Implementation/ Upgrade (A/I/U).** Eligible professionals or eligible hospitals in their first participation year under the Oklahoma EHR Incentive ~~Payment~~ Program may choose to attest to adopting, implementing, or upgrading certified EHR technology. Proof of A/I/U must be submitted to OHCA in order to receive payment.

(f) **Meaningful use.** Eligible professionals in their second through sixth participation year and eligible hospitals in their second through third participation year must attest to meaningful use of certified EHR technology. Eligible hospitals must attest to meaningful use if they are participating in both the Medicare and Oklahoma EHR Incentive Programs in their first participation year. The definition of "meaningful use" is outlined in, and determined by, the Electronic Health Records Program Final Rule CMS-0033-F.

(g) **Payment.** Eligible professionals may receive a maximum of $63,750 in incentive payments over six (6) years. Providers must begin their participation by 2016 to be eligible for payments. Payments will be made one (1) time per year per provider and will be available through 2021. Eligible hospitals cannot initiate payments after 2016 and payment years must be consecutive after 2016.

(1) Eligible professionals and eligible hospitals must use a Taxpayer Identification Number (TIN) to assign a valid entity as the incentive payments recipient. Valid entities may be the individual provider or a group with which the provider is associated. The assigned payee must have a current Provider Agreement with OHCA.

(2) The provider is responsible for repayment of any identified overpayment. In the event OHCA determines monies have been paid inappropriately, OHCA will recoup the funds by reducing any future payments owed to the provider.

(h) **Administrative appeals.** Administrative appeals of decisions related to the Oklahoma ~~Electronic Health Records~~EHR Incentive Program will be handled under the procedures described in OAC ~~317:2-1-2(b)~~317:2-1-2(c). The only exception to this section is when CMS conducts meaningful use audits. Results of any adverse CMS audits are subject to the CMS administrative appeals process and not the state appeal process.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than ~~12~~twelve (12) months.

(1) **Determination of categorical relationship to the disabled by ~~SSA~~Social Security Administration (SSA).** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for ~~SSI~~Supplemental Security Income (SSI) on disability.** If the applicant, under age ~~65~~sixty-five (65), states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for**

SSI. If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of ~~12~~twelve (12) months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability

benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, ~~TPQY~~third party query procedure (TPQY) is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received within ~~12~~twelve (12) months from the date of medical services. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two (2) months after hospital release. The details of the verification used are recorded in the case record.

(2) **Determination of categorical relationship to the disabled by the LOCEU.**

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

(i) have been determined ineligible by SSA on some condition of eligibility other than disability,

(ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or

(iii) do not have a disability which would normally be expected to last ~~12~~twelve (12) months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last ~~12~~twelve (12) months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local ~~OKDHS~~DHS office is responsible for submitting a medical social summary on ~~OKDHS~~DHS form ABCDM-80-D 08MA022E with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and ~~OKDHS~~DHS Form 08MA005E are not normally considered pertinent medical information by themselves. Current (less than ~~90~~ninety (90) days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county

administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of ~~OKDHS~~DHS form 08MA016E, Authorization for Examination and Billing. The ~~OKDHS~~DHS worker sends the 08MA016E and ~~OKDHS~~DHS form 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(i) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(I) The decision as to whether the applicant is related to Aid to the Disabled.

(II) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(III) A request for additional medical and/or social information when additional information is necessary for a decision.

~~(IV) Authorizing specialists' examinations as needed.~~

~~(V) Setting a date for re-examination, if needed.~~

~~(ii) **Specialist's examination.** If, on receipt of the medical information from the county office, the LOCEU needs additional medical information, the LOCEU may, at their discretion, make an appointment for a specialist's examination by a physician selected by the medical member of the team and authorize it on Form M-S-32, Request to Physician for Examination and Authorization for Billing, routing the original of the form to the examining physician and a copy to the county office. As soon as the county receives a copy of Form M-S-32, the worker immediately notifies the individual of the appointment and explains that failure to keep the appointment with the specialist without good cause will result in denial of the application (or closure of the case in instances of determination of continuing disability). The worker assists the individual in keeping the appointment, if necessary.~~

~~(I) If the specialist requires additional laboratory work or X-rays, he/she should call the LOCEU for authorization. The LOCEU is responsible for making the decision regarding the request. If additional medical~~

~~services are authorized, another Form M-S-32 will be completed.~~

~~(II) If the individual notifies the worker at least 24twenty-four (24) hours prior to the date of the examination that he/she cannot keep the appointment, this constitutes good cause. In such an instance, the worker cancels the appointment, makes a new appointment, and submits information regarding the cancellation and the date of a new appointment to the LOCEU.~~

~~(III) When the individual fails to keep the appointment without advance notice, good cause must be determined. The worker determines the reasons and submits a memorandum to the LOCEU for a decision on good cause.~~

~~(IV) If the appointment was missed due to illness, the illness must be supported by a written statement from a physician. If missed for some reason other than illness, the reason must be supported by an affidavit signed by someone other than the individual or his/her representative and sworn to before a notary public or other person authorized to administer oaths. If, in the opinion of the LOCEU, good cause is established, the LOCEU and the county follow the same procedures as outlined in (2)(C)(ii) of this Section for any other specialist's examination. If, in the opinion of the LOCEU, good cause is not established, the LOCEU notifies the local office. The local office is responsible for denying the application or closing the case with notification to individual in accordance with OHCA and Department policy.~~

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the ~~county~~Oklahoma Health Care Authority (OHCA) uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/IIDs, or inpatient acute care hospital stays expected to last not less than ~~60~~sixty (60) days. In addition to disability, LOCEU determines the appropriate level of care and cost effectiveness.

(3) **Determination of categorical relationship to the disabled**

based on ~~TB~~Tuberculosis (TB) infection. Categorical relationship to disability is established for individuals with a diagnosis of ~~tuberculosis (TB)~~TB. An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.
(4) **Determination of categorical relationship to the disabled for TEFRA.** Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under ~~19~~nineteen (19) years of age, living at home who are disabled as defined by the ~~Social Security Administration~~SSA, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of ~~60~~sixty (60) days), nursing facility or intermediate care facility for individuals with intellectual disabilities, is determined eligible using only his/her income and resources as though he/she were institutionalized.

317:35-5-4.1. Special level of care and cost effectiveness application procedures for ~~TEFRA~~Tax Equity and Fiscal Responsibility Act (TEFRA)

(a) In order for a child to be eligible for TEFRA, he/she must require a level of care provided in an acute care hospital for a minimum of ~~60~~sixty (60) days, or a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICFIID) for a minimum of ~~30~~thirty (30) days. It must also be appropriate to provide care to the child at home. The level of care determination is made by LOCEU. The level of care certification period may be for any number of months that the LOCEU determines appropriate. At the time of application, an assessment form is provided to the applicant for completion by the child's physician. Once completed by the physician and returned to the ~~OKDHS worker~~Oklahoma Health Care Authority, the assessment form is forwarded to the LOCEU along with the request for a disability determination (if needed).

(b) The estimated cost of caring for the child at home must not exceed the estimated cost of treating the child within an institution at the appropriate level of care, i.e., hospital, NF, or ICF/IID. The initial cost analysis is established by LOCEU based on the information provided by the TEFRA-1 Assessment form~~, OKDHS worker,~~ and medical information used in the relationship to disability determination.

(c) The level of care determination and cost effectiveness analysis are reported by LOCEU annually.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-49. Determination of income and resources for categorical relationship to ~~TEFRA~~Tax Equity and Fiscal Responsibility Act (TEFRA)

Countable income and resources for a child categorically related to disability for TEFRA are determined in accordance with rules for individuals determined aged, blind, or disabled (see ~~OAC~~Oklahoma Administrative Code 317:35-5-41 through 317:35-5-41.11, 317:35-5-42, and 317:35-7-36). ~~Income and resources may not exceed the maximum standards as shown on OKDHS Appendix C-1, Schedules VIII. B. and D~~The family is required to declare their household income so that the Oklahoma Health Care Authority may determine if the child qualifies for the TEFRA program or is otherwise SoonerCare eligible.

SUBCHAPTER 7. MEDICAL SERVICES

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-61.1. Special redetermination procedures for ~~TEFRA~~Tax Equity and Fiscal Responsibility Act (TEFRA)

In addition to redetermining the level of care annually, the OHCA also conducts an annual cost effectiveness review for all active TEFRA children. ~~The local county office is notified of the results of the review for any necessary case action.~~ If OHCA determines the child does not meet any level of care, is no longer disabled, or the estimated cost of care in the home is greater than the estimated cost of care in an institution, at the appropriate level of care, the case is closed.

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

SUBCHAPTER 21. OKLAHOMA CARES BREAST AND CERVICAL CANCER TREATMENT PROGRAM

317:35-21-1. Oklahoma Cares Breast and Cervical Cancer Treatment (BCC) program

(a) The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) allows states to provide Medicaid to uninsured women under age ~~65~~sixty-five (65) who are in need of treatment for breast and/or cervical cancer. A medical eligibility evaluation is performed through the Centers for Disease Control (CDC) and Prevention's ~~(CDC)~~ National Breast and Cervical Cancer Early Detection Program (NBCCEDP). If the evaluation determines the woman is in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage, recurrent or metastatic cancer the case is forwarded to ~~OHCA~~Oklahoma Health Care Authority (OHCA) for final medical eligibility determination.

(b) To receive Breast and Cervical Cancer (BCC) Treatment services, the woman must meet all of the following conditions.

(1) The woman must have been screened for BCC under the CDC Breast and Cervical Cancer Early Detection Program ~~(see OAC Code (OAC) 317:35-21-3)~~[see Oklahoma Administrative Code (OAC) 317:35-21-3] established under Title XV of the Public Health Service ~~(PHS)~~ Act, and upon screening examination found to be in need of treatment, including an abnormal finding that is potentially indicative of a cancerous or precancerous condition or found to have an early stage, recurrent or metastatic cancer of the breast or cervix. (see OAC 317:35-21-5).

(2) The woman must:

(A) not have creditable insurance coverage that covers the treatment of breast or cervical cancer (see OAC 317:35-21-4),

(B) not be eligible for any other categorically needy SoonerCare eligibility group,

(C) be under ~~65~~sixty-five (65) years of age,

(D) be a US citizen or qualified alien (see OAC 317:35-5-25 for citizenship/alien status and identity verification requirements),

(E) be a resident of Oklahoma,

(F) declare her Social Security number,

(G) assign her rights to Third Party Liability if she has insurance that is not creditable, and

(H) declare her household income for the purpose of determining eligibility for services under the SoonerCare

program.

317:35-21-3. CDC screening

(a) To be eligible for the ~~Oklahoma Cares Breast and Cervical Cancer Treatment~~BCC program, a woman must be screened under the CDC Breast and Cervical Cancer Early Detection Program. A woman is considered screened under the CDC program if her screening was provided all or in part by CDC Title XV funds, or the service was rendered by a provider funded at least in part by CDC Title XV funds, and/or if she is screened by another provider whose screening activities are pursuant to CDC Title XV of the Public Health Service ~~(PHS)~~ Act.

(b) Prior to certification of the BCC application an OHCA Care Management nurse must review the application and clinical data to verify the BCC applicant meets medical eligibility criteria for the BCC program.

(c) Upon verification by OHCA Care Management, the application is forwarded to the ~~OKDHS worker~~eligibility coordinator to verify ~~that~~ the BCC applicant was screened by a CDC provider and meets criteria for the program as outlined in OAC 317:35-21-1.

317:35-21-4. Creditable coverage

(a) Creditable coverage when used in this subchapter means any insurance that pays for medical bills incurred for the diagnosis and/or treatment of breast or cervical cancer. A woman having any one of the following types of coverage is considered to have creditable coverage and would normally be ineligible for the ~~Breast and Cervical Cancer Treatment~~BCC program:

(1) Coverage under a group health plan;

(2) Health insurance coverage, i.e., benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer;

(3) Medicare Part A and/or B;

(4) SoonerCare;

(5) Armed Forces insurance; and/or

(6) A state health risk pool.

(b) If a woman has limited coverage, such as limited drug coverage or limits on the number of outpatient visits, or high deductibles, she is still considered to have creditable coverage. However, if she has a policy with limited scope coverage such as those that only cover dental, vision, or long term care, or a policy that covers only a specific disease or illness, she is not considered to have creditable coverage, unless the policy provides coverage for breast or cervical cancer.

(c) There may be some circumstances when a woman has creditable coverage but that coverage does not actually cover treatment of

breast or cervical cancer. In instances such as pre-existing condition exclusions, or when the annual or lifetime limit on benefits has been exhausted, a woman is not considered to have creditable coverage for this treatment. In these types of circumstances the woman may be eligible for ~~Breast and Cervical Cancer~~BCC services if she meets all other eligibility criteria.
(d) There is no requirement that a woman be uninsured for any specific length of time before she is found eligible for SoonerCare under this program. If a woman loses creditable coverage for any reason and satisfies all other eligibility requirements for the BCC program, it is possible for her to become immediately eligible for coverage in this program.
(e)~~ The CDC screener evaluates whether or not the woman has creditable coverage. All health insurance, creditable or not, is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage. Questionable insurance coverage is noted in the application by the CDC screener. Applications with questionable insurance coverage are forwarded to the OHCA Third Party Liability Unit for further verification.~~ The existence of creditable coverage will be verified by the OHCA eligibility coordinator.

317:35-21-5. In need of treatment

In need of treatment, when used in this subchapter, means an abnormal screen determined as a result of a screening for BCC under the CDC BCC Early Detection Program established under Title XV of the Public Health Service Act, indicating pre-cancerous conditions and early stage, recurrent or metastatic cancer. Services include diagnostic services for an abnormal finding that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Women who are determined to require only routine monitoring services for precancerous breast or cervical condition (e.g., breast examinations, mammograms, pelvic exams and pap smears) are not considered to be "in need of treatment". The American Society for Colposcopy and Cervical Pathology Consensus and National Comprehensive Cancer Network guidelines are used to make the "in need of treatment" determination.

317:35-21-6. Age requirements

To be eligible for the ~~Oklahoma Cares Breast and Cervical Cancer Treatment~~BCC program, a woman must be under ~~65~~sixty-five (65) years of age. If a woman turns ~~65~~sixty-five (65) during the certification period, eligibility ends effective the last day of her birth month. The ~~OKDHS worker~~eligibility coordinator assists the woman in determining if eligibility may continue in another SoonerCare category.

317:35-21-9. Income

(a) There is no income limit imposed by ~~state or federal law~~State or Federal law for the ~~Breast and Cervical Cancer Treatment~~BCC program. However, the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service ~~(PHS)~~ Act does allow CDC program grantees to set maximum income limits.

(b) Income limits are established for women receiving ~~Breast and Cervical Cancer Treatment~~BCC program services through SoonerCare. The woman is required to declare her household income so that the ~~OKDHS worker~~eligibility coordinator may determine if she qualifies for the program or is otherwise SoonerCare eligible.

317:35-21-11. Certification for BCC

(a) In order for a woman to receive BCC treatment services, she must first be screened for BCC ~~cancer~~ under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and found to be in need of treatment. Once determined to be in need of treatment, the CDC screener determines that the woman:

(1) does not have creditable health insurance coverage,
(2) is under age ~~65,~~sixty-five (65),
(3) is a US citizen or qualified alien (see OAC 317:35-5-25),
(4) is a ~~self declared~~self-declared Oklahoma resident,
(5) has provided her social security number,
(6) is willing to assign medical rights to ~~TPL,~~Third Party Liability, and
(7) has declared all household income.

(b) If all of the conditions in subchapter (a) are met, the CDC screener assists the woman in completing the BCC application (OHCA BCC-1). The completed BCC-1 along with the documentation of clinical findings, (i.e., history and physical findings, pathology reports, radiology reports and other pertinent data) is forwarded to the OHCA Care Management Unit.

(c) ~~The~~An OHCA Care Management nurse verifies that the member meets the medical eligibility criteria described in OAC 317:35-21-1 (a) and meets the "in need of treatment" criteria set forth in OAC 317:35-21-1(b)1 and 317:35-21-5. If this criteria is not met or the appropriate clinical documentation is not included, the application will be denied and the OHCA will send a notice of ineligibility to the applicant. Abnormal findings do not include women who are at high risk or who could appropriately receive risk reduction therapy, but have no evidence of cancer or a precancerous condition. If it is determined that the woman does not have cancer or a precancerous condition, a future application for the BCC program must be based on a different finding of abnormality than the previous application data.

(d) If all medical eligibility criteria are met, the application

will be forwarded to ~~OKDHS~~the eligibility coordinator for further determination of eligibility.
(e) The ~~OKDHS worker~~eligibility coordinator verifies that the screener is a CDC screener. The ~~worker~~eligibility coordinator also establishes whether or not the woman is otherwise eligible for SoonerCare. If the woman is not otherwise eligible for SoonerCare, she is certified for the BCC program. If the woman is eligible under another SoonerCare category, the application is certified in the other Medicaid category.
(f) If a woman does not cooperate in determining her eligibility for other SoonerCare programs, her BCC application is denied and the appropriate notice is computer generated. For example, if a woman otherwise eligible for SoonerCare, related to the low income families with children category, refuses to cooperate with child support enforcement without good cause would not be eligible for the BCC program.
(g) If a woman in treatment for breast or cervical cancer contacts the ~~OKDHS office~~OHCA and has not been through the CDC screening process, she is referred to the Oklahoma Cares toll free number (866-550-5585) for assistance.
(h) An individual determined eligible for the ~~Oklahoma Cares Breast and Cervical Cancer Treatment~~BCC program may be certified the first day of the month of application. If the individual had a medical service prior to the application date, certification will occur the first day of the first, second or third month prior to the month of application, in accordance with the date of the medical service, provided the date of certification is not prior to the CDC Screen.

317:35-21-12. Changes after certification/continued need for treatment
(a) A woman found to be in need of treatment as the result of an abnormal BCC screen has ~~60~~sixty (60) days from the date of the application to complete the initial appointment for a diagnostic procedure and an additional ~~60~~sixty (60) days to complete any additional diagnostic testing required or to initiate compensable treatment for a cancerous or pre-cancerous condition. The exception to the time limit is evidence of a lack of appointment availability. Upon completion of the diagnostic testing, OHCA is provided a medical report of the findings.

(1) If the woman is found not to have breast or cervical cancer including pre-cancerous conditions and early stage, recurrent or metastatic cancer for which she is in need of treatment or fails to have diagnostic testing or begin treatment within the time frames described in OAC 317:35-21-12(a), the case is closed by ~~OKDHS~~OHCA and appropriate notification is computer generated.

(2) If a medical report necessary to determine continued treatment is not received from a provider within ten (10) working days after a request is made by OHCA, the report is considered negative and the case is closed by ~~OKDHS~~OHCA and appropriate notification is computer generated.

(b) If the woman in need of treatment refuses SoonerCare compensable treatment or diagnostic services and does not plan to pursue the care in the time frames described in OAC 317:35-21-12(a), the case is closed by ~~OKDHS~~OHCA and appropriate notification is computer generated.

(c) In the event a woman is unable to initiate or complete diagnostic services due to a catastrophic illness or injury occurring after certification, SoonerCare will remain open with the approval of a ~~SoonerCare Medical Director~~Chief Medical Officer or his/her designee.

(d) If it is determined at any time during the certification period by either the woman's treating physician or by a ~~SoonerCare Medical Director~~Chief Medical Officer or his or her designee that the woman is no longer in need of treatment for breast or cervical cancer or a precancerous condition, ~~OHCA will notify OKDHS and the OKDHS worker~~the eligibility coordinator closes the case and appropriate notification is computer generated.

(e) If it is determined at any time during the certification period that the woman has creditable health insurance coverage, the ~~OKDHS worker~~eligibility coordinator closes the case and appropriate notification is computer generated.

(f) If the ~~OKDHS worker~~eligibility coordinator later determines that the woman is otherwise eligible for SoonerCare, the worker takes necessary actions to certify her for the appropriate category of SoonerCare coverage.

317:35-21-14. Appeals and reconsiderations

(a) Applicants who wish to appeal a denial decision made by the OHCA ~~or OKDHS~~ may submit form LD-1 to the OHCA within ~~20~~thirty (30) days of receipt of the decision notification. If the form is not received at the OHCA within the required time frame, the appeal will not be heard. More information on the appeals process is provided at OAC 317:2-1-2(a).

(b) Reconsiderations to the OHCA may be requested by a CDC screener if missing documentation, ~~that~~which could potentially result in a determination of eligibility, has been obtained. The missing documentation must be presented within ~~30~~thirty (30) days of the date of the notice of denial.

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

SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in ~~PACE,~~Programs of All-Inclusive Care for the Elderly (PACE), the applicant must:

(1) be age ~~55~~fifty-five (55) years or older;

(2) live in a PACE service area;

(3) be determined by the state to meet nursing facility level of care; and

(4) be determined by the PACE ~~Interdisciplinary~~interdisciplinary team (IDT) as able to be safely served in the community at the time of enrollment. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:

(A) notify the applicant in writing of the reason for the denial;

(B) refer the applicant to alternative services as appropriate;

(C) maintain supporting documentation for the denial and notify ~~CMS~~the Centers for Medicare and Medicaid Services and ~~OHCA~~the Oklahoma Health Care Authority (OHCA) of the denial and make the supporting documentation available for review; and

(D) advise the applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for SoonerCare capitated payments, the individual must:

(1) meet categorical relationship ~~to disability (reference OAC 317:35-5-4).~~for the aged, blind, or disabled [refer to Oklahoma Administrative Code (OAC) 317:35-5-4];

(2) be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services~~;~~ (DHS);

(3) be eligible for SoonerCare State Plan services;

(4) meet the same financial eligibility criteria as set forth for the SoonerCare ~~Advantage~~ADvantage program per OAC 317:35-17-10 and 317:30-17-11;~~and~~ and

(5) meet appropriate medical eligibility criteria.

(c) The nurse designee makes the medical determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) Part I, Part III, and other available medical information.

(1) When PACE services are requested:

(A) The PACE nurse or ~~OKDHS~~DHS nurse is responsible for completing the UCAT assessment.

(B) The PACE intake staff is responsible for aiding the PACE enrollee in contacting ~~OKDHS~~DHS to initiate the financial eligibility application process.

(2) The nurse completes the UCAT, Part III visit with the PACE enrollee, in the participant's home, within ~~10~~ten (10) days of receipt of the referral for PACE services.

(3) The nurse sends the UCAT, Part III to the designated OHCA nurse staff member for review and level of care determination.

(4) A new medical level of care determination may be required when a member requests any of the following changes in service programs:

(A) ~~From~~from PACE to ~~Advantage.~~ADvantage;

(B) ~~From~~from PACE to State Plan Personal Care Services~~.~~;

(C) ~~From~~from Nursing Facility to PACE~~.~~;

(D) ~~From Advantage~~from ADvantage to PACE if previous UCAT was completed more than ~~6~~six (6) months prior to member requesting PACE enrollment~~.~~; or

(E) ~~From~~from PACE site to PACE site.

(d) To obtain and maintain eligibility, the individual must agree to accept the PACE providers and its contractors as the individual's only service provider. The individual may be held financially liable for services received without prior authorization except for emergency medical care.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-761. Eligible providers

~~Advantage~~ADvantage Program service providers, except pharmacy providers, must be certified by the ADvantage Program ADvantage Administration (AA) and~~ all providers~~ must have a current signed SoonerCare (Medicaid) contract on file with the Oklahoma Health Care Authority (OHCA), the State Medicaid ~~Agency.~~agency.

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

(2) The provider ~~financial certification~~financial-certification process must verify that the provider uses sound business management practices and has a ~~financially stable~~financially-stable business. All providers, except for nursing facility (NF) respite, medical equipment and supplies, and environmental modification providers, must obtain financial certification to be ADvantage ~~Program~~program certified.

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

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

(5) The Oklahoma Department of Human Services (DHS) Aging Services (AS) evaluates adult day health and home-delivered meal providers for compliance with ADvantage ~~programmatic certification~~programmatic-certification requirements. When an adult day health or home-delivered meal provider does not have a contract with AS, the provider must obtain programmatic certification to be ADvantage ~~program~~Program certified. ~~For assisted living services provider programmatic certification, the ADvantage program relies in part upon the Oklahoma State Department of Health Protective Health Services for review and verification of provider compliance with ADvantage standards for assisted living services providers.~~ Providers of medical equipment and supplies, environmental modification, personal emergency response systems, hospice, Consumer-Directed ~~personal~~Personal Assistance Services and Supports (CD-PASS),

and NF respite services do not have a programmatic evaluation after the initial certification.

(6) DHS AS does not authorize ~~a legal guardian for a member or~~ an active power of attorney ~~for~~of a member to be ~~that CD-PASS~~the member's CD-PASS services provider.

(7) ~~DHS AS may authorize a member's legally-responsible spouse to be SoonerCare reimbursed per 1915(c) ADvantage Program as a service provider.~~

~~(8)~~ DHS AS may authorize a member's legally-responsible spouse or legal guardian to be SoonerCare (Medicaid) reimbursed, per 1915(c) ADvantage Program as a personal care, service provider ~~except as a provider of CD-PASS services~~. Authorization for a spouse or legal guardian as a provider requires the criteria in (A) through (D) and monitoring provisions to be met.

(A) Authorization for a spouse or legal guardian to be the care provider for a member may occur only when the member is offered a choice of providers and documentation demonstrates:

(i) ~~no other provider is available; or~~no provider included on the Certified Agency Report (CAR) has available staffing; This is as evidenced by supportive documentation, which affirms no provider within the members service area can staff and all area providers attempt to employ staff to serve; or

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

~~(iii)~~ the member's needs are so ~~extensive~~complex that unless the spouse or legal guardian ~~providing~~provides the care, ~~is prohibited from working outside of the home due to the member's need for care.~~the member's risk level would increase; and

(iii) it is mentally or physically detrimental for someone other than the spouse or legal guardian to provide care. This is evidenced by the documentation from a qualified clinician or medical provider such as a physician or licensed psychologist.

(B) The service must:

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

(ii) be necessary to avoid institutionalization;

(iii) be a service/support specified in the person-centered service plan;

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

payment of personal care or personal assistance services; and

(vi) not be an activity the spouse or legal guardian would ordinarily perform or is responsible to perform. ~~When any of the following criteria are met, assistance or care provided by the spouse or guardian is determined to exceed the extent and/or nature of the assistance he or she is expected to ordinarily provide as spouse or guardian. The spouse or guardian:~~

~~(I) resigned from part-time or full-time employment to provide care for the member; or~~

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

~~(III) took a leave of absence without pay to provide care for the member; or~~

~~(IV) provides assistance and/or care for the member 35 or more hours per week without pay and the member has remaining unmet needs because another provider is unavailable due to the nature of the assistance and/or care, special language or communication needs, or the member's intermittent hours of care requirements.~~

(C) The spouse or legal guardian service provider complies with:

(i) ~~not~~ providing no more than ~~40~~forty (40) hours of services in a seven-day (7-day) period;

(ii) planned work schedules that must be available in advance for the member's case manager, and variations to the schedule must be noted and supplied to the case manager two (2) weeks in advance unless the change is due to an emergency;

(iii) maintaining and submitting time sheets and other required documentation for hours paid; and

(iv) ~~is documented in~~ the person-centered service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all ~~Waiver~~waiver services, the ~~state~~State is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The AA monitors, through quarterly documentation submitted by the case manager, ~~at least quarterly: expenditures, monthly home visits with member, and the health safety, and welfare status of the individual member.~~the continued appropriateness of the policy exception that allows the spouse or legal guardian to serve as the member's paid caregiver.

~~(9)~~(8) Providers of durable medical equipment and supplies must comply with Oklahoma Administrative Code 317:30-5-210(2) regarding proof of delivery for items shipped to the

member's residence.

~~(10)~~(9) DHS AS periodically performs a programmatic audit of adult day health, assisted living, case management, home care (providers of skilled nursing, personal care, in-home respite, and advanced supportive/restorative assistance and therapy services) and CD-PASS providers. ~~If~~When due to a programmatic audit, a provider Plan of Correction (POC) is required, the AA may stop new cases and referrals to the provider until the ~~Plan of Correction~~(POC) is approved, implemented, and follow-up review occurs. Depending on the nature and severity of problems discovered during a programmatic audit~~,~~ and at the discretion of the DHS AS, members determined to be at risk for health or safety may be transferred from a provider requiring a ~~Plan of Correction~~POC to another provider.

317:30-5-763. Description of services

Services included in the ADvantage Program are:

(1) **Case management.**

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

(i) initiate and oversee necessary assessments and reassessments to establish or reestablish ~~Waiver~~waiver program eligibility;

(ii) develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

(iii) initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) helps the member transition from institution to home by updating the person-centered service plan;

(III) prepares services to start on the date the member is discharged from the institution; and

(IV) must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ~~AA~~ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency person-centered planning.

(C) Providers may only claim time for billable case management activities, described as:

(i) any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training, or authority can perform on behalf of a member; and

(ii) ancillary activities, such as clerical tasks including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

(D) Case management services are prior authorized and billed per ~~15-minute~~fifteen-minute (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 a population density greater than ~~25~~twenty-five (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 a population density equal to, or less than ~~25~~twenty-five (25) persons per square mile. Exceptions are services to members who reside in Oklahoma ~~DHS AS~~Department of Human Services (DHS) Aging Services

identified ~~Zip~~zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington ~~Counties.~~counties. Services to these members are prior authorized and billed using the standard rate.

(iii) The latest United States Census, Oklahoma ~~Counties~~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~~twenty-five (25) persons per square mile, or resides in a county with a population density greater than ~~25~~twenty-five (25) persons per square mile.

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a ~~nursing facility.~~NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per ~~15-minute~~fifteen-minute (15-minute) units of service. Within any one-day (1-day) period, a minimum of eight (8) units ~~(2 hours~~[two (2) hours] must be provided with a maximum of ~~28 units (7 hours)~~twenty-eight (28) units [seven (7) hours] provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate when provided in a ~~nursing facility.~~NF. Extended respite must be at least eight (8) hours in duration.

(D) In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(3) **Adult day health (ADH) care.**

(A) ADH is furnished on a regularly-scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral services to ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ADH care is a ~~15-minute~~fifteen-minute (15-minute) unit of service. No more than eight (8) hours, ~~32~~thirty-two (32) units ~~(eight hours)~~[eight (8) hours] are authorized per day. The number of units of service a member may receive is

limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.

(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, is provided to those participants who are in the center for four (4) or more hours per day, and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.

(E) ~~Personal care~~Personal-care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when ~~as~~an ADvantage Waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry service is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.

(F) DHS Home and Community-Based Services (HCBS) Waiver settings have qualities defined in federal regulation, per Section (§) 441.301 (c)(4) of Title 42 of Code of Federal Regulations (CFR) ~~[42 CFR ' 441.301 (c)(4)]~~ based on the individual's needs, ~~of the individual~~ defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;

(II) engage in community life;

(III) control personal resources; and

(IV) receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS Waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:

(I) daily activities;

(II) the physical environment; and

(III) with whom to interact.

(v) The ADH facilitates the member's choice regarding services and supports including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be ~~Home and Community-Based~~HCBS settings per 42 CFR § 441.301(c)(5)(v) include~~:~~, ADH centers:

(i) ~~ADH centers~~ in a publicly- or privately-owned facility providing inpatient treatment;

(ii) ~~ADH centers~~ on the grounds of or adjacent to a public institution; and

(iii) ~~ADH centers~~ with the effect of isolating individuals from the broader community of individuals not receiving ADvantage Program or another Medicaid HCBS;

(H) ~~If~~When the ADH is presumed not HCBS, according to 42 CFR § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, OHCA, and ~~CMS.~~Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications**.

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety~~ of the member~~ or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home not of direct medical or remedial benefit to the ~~Waiver~~waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered

service plan that enable members to increase their abilities to perform ~~Activities of Daily Living (ADLs),~~ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid ~~state plan~~State Plan are also included. This service excludes any equipment and/or supply items not of direct medical or remedial benefit to the ~~Waiver~~waiver member~~. This service is~~ and necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus ~~30~~thirty (30) percent. All services must have prior authorization.

(6) **Advanced supportive/restorative assistance**.

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B) Advanced supportive/restorative assistance service is billed per ~~15-minute~~fifteen-minute (15-minute) unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the Oklahoma Nursing Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice in the state. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either the Medicaid or ~~the~~ Medicare 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 they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage Program case manager in accordance with review schedule determined between the case manager and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage Program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

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

(II) 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 per rules and regulations for the delegation of nursing tasks established by the Oklahoma Board of Nursing.

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

(I) prepare a one-week (1-week) supply of insulin syringes for a person who is blind and has diabetes~~,~~ ~~who~~and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

(II) prepare 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) monitor 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) provide nail care for the member with diabetes or member who has circulatory or neurological compromise; and

(V) provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the Oklahoma Nursing Practice Act, including private duty nursing. Nursing services are billed per ~~15-minute~~fifteen-minite (15-minute) unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units, two (2) hours, per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled nursing services.**

(A) Skilled nursing services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act and are ordered by a licensed physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by an RN, LPN, or LVN under the supervision of an RN, licensed to practice in the state. Skilled nursing services provided in the member's home or other community setting are services requiring the

specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per ~~15-minute~~fifteen-minute (15-minute) units of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **Home-delivered meals.**

(A) Home-delivered meals provide one (1) 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 dietary reference intakes as established by the Food and Nutrition Board of the National Academy of Sciences. Home-delivered 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 (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

(A) Occupational therapy services are 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 enabling him or her 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 limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve 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 the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/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. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed ~~30-calendar~~thirty-calendar (30-calendar) days. Any treatment required after the ~~30-calendar~~thirty-calendar (30-calendar) day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her 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 when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services are authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/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 the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes Speech Language Pathology Assistant services within the limitations of his or her practice, working under the supervision of the licensed Speech and Language Pathologist. The regimen includes education and training for informal caregivers to assist with, and/or maintain services when appropriate. The Speech and Language Pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH ~~care therapy~~care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice services.**

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six (6) months or less, and orders hospice care. ADvantage hospice care is authorized for a six-month (6-month) period and requires physician certification of a terminal illness and orders of hospice care. When the member

requires more than six (6) months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member ~~30-calendar~~thirty-calendar (30-calendar) days prior to the initial hospice authorization ~~end date,~~end-date, and re-certify that the member has a terminal illness, has six (6) months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of ~~60-calendar~~sixty-calendar (60-calendar) day increments with physician certification that the member has a terminal illness and six (6) months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements to be within total person-centered service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with 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 illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage 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 member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a ~~12-month~~twelve-month (12-month) period is limited to an amount equivalent to ~~85~~eighty-five (85)

percent of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per ~~15-minute~~fifteen-minute (15-minute) unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

(15) **Personal emergency response system~~.~~ (PERS).**

(A) ~~Personal emergency response system (PERS)~~PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all of the service criteria in (i) through (vi). The:

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

(ii) member lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

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

(B) PERS services are billed using the appropriate Healthcare Common Procedure Coding System ~~(HCPC)~~(HCPCS) procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the ADvantage approved service plan.

(16) **CD-PASS.**

(A) CD-PASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that ~~enable~~enables a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

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

(ii) is solely responsible to provide instruction and training to the PSA or APSA on tasks and works with the consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an APSA 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.

(B) The services the PSA may provide include:

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

(ii) assistance with routine bodily functions, such as:

(I) bathing and personal hygiene;

(II) dressing and grooming; and

(III) eating, including meal preparation and cleanup;

(iii) assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;

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

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who when appropriate, ~~order~~orders home health services. APSA includes assistance with health maintenance activities that may include:

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

(ii) removing external catheters, inspecting skin, and reapplication of same;

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

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

(v) using a lift for transfers;

(vi) manually assisting with oral medications;

(vii) providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with

the person-centered service plan unless contraindicated by underlying joint pathology;

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

(ix) using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by AA. FMS 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) processing employer payroll, after the member/employer has verified and approved the employee timesheet, 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/employer and in accordance with the member/employer's individual budget allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;

(iv) providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member successfully perform employer-related functions; and

(v) making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service is billed per ~~15-minute~~fifteen-minute (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 person-centered service plan.

(F) The APSA service is billed per ~~15-minute~~fifteen-minute (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 person-centered service plan.

(17) **Institutional transition services.**

(A) Institutional transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage ~~Waiver~~waiver services in his or her home and community.

(B) Transitional case management services are services per ~~Oklahoma Administrative Code (OAC)~~OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety~~ of the member~~, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed Waiver and other State plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member transition from institution to home by updating the person-centered service plan, including necessary institutional transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by DHS AS to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institutional transition case management services are prior authorized and billed per ~~15-minute~~fifteen-minute (15-minute) unit of service using the appropriate ~~Healthcare Common Procedure Coding (HCPC)~~HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish transitional case management services from regular case management services.

(C) Institutional transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institutional transition services are provided to the member within ~~180~~one-hundred and eighty (180) calendar-days of discharge from the institution.

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

(D) When the member receives institutional transition services but fails to enter the ~~Waiver,~~waiver, any institutional transition services provided are not reimbursable.

(18) **Assisted living services (ALS).**

(A) ALS are personal care and supportive services furnished to ~~Waiver~~waiver members who reside in a homelike, non-institutional setting that includes ~~24-hour,~~twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center~~.~~ (ALC). Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who

choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) rental unit availability;

(II) the member's compatibility ~~of the member~~ with other residents;

(III) the center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. At minimum, the ALC must designate ~~10~~ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC ~~if~~when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate, cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ~~ADvantage Administration (AA).~~AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the Oklahoma State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide up to three (3) meals per day plus snacks sufficient to meet nutritional requirements, including

modified special diets, appropriate to the member's needs and choices; and provide members with ~~24-hour~~twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, ~~will be~~is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person, and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage

case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions exist.

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well-being of other residents and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ALC attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ALC attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges and/or DHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, ~~and~~ the member's representative, when ~~any,~~applicable, the AA and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA~~,~~.~~giving the member 30-calendar days~~ The written notice ~~of the ALC's~~provides intent to terminate the residency agreement and move the member to an appropriate care provider. The ~~30-calendar day~~thirty (30) calendar-day requirement must not apply when emergency termination

of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written ~~notice of~~ involuntary termination of residency notice for reasons of inappropriate placement must include:

(I) a full explanation of the reasons for the termination of residency;

(II) the notice date;

(III) the date notice was given to the member and the member's representative, the ADvantage ~~Case Manager,~~case manager, and the AA;

(IV) the date the member must leave ALC; and

(V) notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) Physical environment.

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the ~~Oklahoma State Department of Health~~OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of

~~250~~two-hundred and fifty (250) square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of ~~360~~three-hundred and sixty (360) square feet.
(V) The ALC must provide a private bathroom for each living unit that must be equipped with one lavatory, one toilet, and one bathtub or shower stall.
(VI) The ALC must provide at a minimum~~,~~; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance, a microwave is acceptable.
(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if member supplied furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.
(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.
(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per 28 Code of Federal Regulations, Part 36, Appendix A, at no additional cost to the member.
(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.
(XI) The ALC must provide appropriately monitored outdoor space for resident use.
(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed~~, but may be limited by the ALC to the extent to which a visitor may stay overnight.~~ as permissible by the Landlord/Tenant Agreement.
(XIII) The ALC must be physically accessible to

members.

(ii) Sanitation.

(I) The ALC must maintain the facility, including its individual rental units ~~that are~~ in a clean, safe, and sanitary manner~~, that are~~ and be insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) Health and Safety.

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the ~~Oklahoma State Department of Health (OSDH).~~OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals.

(X) The ALC must provide a ~~24-hour~~twenty-four (24) hour response to personal emergencies~~ that is~~

appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) Staff to resident ratios.

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, ~~24 hours~~twenty-four (24) hours a day, and seven (7) days a week, to meet the needs of residents and to carry out all of the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ~~the~~ADvantage Program members' needs ~~of the ADvantage Program members~~ in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) Staff training and qualifications.

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) Staff supervision.

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the Oklahoma Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) Resident rights.

(I) The ALC must provide to each member and each member's representative, at the time of admission, a

copy of the resident statutory rights listed in Section 1-1918 of Title 63 of the Oklahoma Statutes ~~(O.S. 63-1-1918)~~ amended to include additional rights and the clarification of rights as listed in the ADvantage Member Assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ~~assisted living center's~~ALC's complaint procedures and the name, address, and ~~telephone~~phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) Incident reporting.

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC are those defined by OSDH, per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting ~~Form.~~form.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. When required, a follow-up report of the incident must be submitted via electronic submission to the member's ADvantage case manager and to the AA. The follow-up report must be submitted within ~~5-business days~~five-business (5-business) days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to

exceed ~~10-business days~~ten-business (10-business) days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per O.S. 43A ' 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at the minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must at the minimum, include preliminary information, the extent of the injury or damage, when any, and preliminary investigation findings. The final report at a minimum includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services. The ALC must:

(I) arrange or coordinate transportation for members to and from medical appointments~~.~~; and

(II) provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ALS are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage assisted living services for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, ~~IADLs,~~instrumental activities of the daily living(IADLs), and health care needs. The rate level is based

on the ~~Universal~~Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ~~90-calendar days~~ninety-calendar (90-calendar) days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage ~~Case Manager 90-calendar days~~case manager ninety-calendar (90-calendar) days before:

(I) voluntary cessation of the ALC's ADvantage contract; or

(II) closure of all or part of the ALC.

(ii) The notice of closure must ~~state:~~include:

(I) the proposed ADvantage contract termination date;

(II) the termination reason;

(III) an offer to assist the member secure an alternative placement; and

(IV) ~~advise the member or member's representative, and the member's ADvantage case manager on~~ available housing alternatives~~;~~.

~~(V) the facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.~~

~~(iii) Following the last move of the last ADvantage member, the ALC must provide in writing to the AA:~~

~~(I) the effective date of closure based on the discharge date of the last resident;~~

~~(II) a list of members transferred or discharged and where they relocated,; and~~

~~(III) the plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.~~

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move to the last ADvantage member, the ALC must provide in writing to the AA:

(I) the effective date of closure based on the discharge date of the last resident;

(II) a list of members transferred or discharged and where they relocated,; and

(III) the plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident

records and the name, address, and phone numbers of the person responsible for the records.

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

SUBCHAPTER 15. PERSONAL CARE SERVICES

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

(a) **Eligibility.** The Oklahoma Department of Human Services (DHS) area nurse determines medical eligibility for personal care services based on the Uniform Comprehensive Assessment Tool (UCAT) Part III and the determination that the member has unmet care needs that require personal care services. Personal care services are initiated to support the ~~informal~~regular care provided in the member's home. Personal care services are not intended to take the place of regular care and general maintenance tasks or meal preparation shared or done for one another by natural supports, such as spouses or other adults who live in the same household. Additionally, personal care services are not furnished when they principally benefit the family unit. To be eligible for personal care services, the individual must:

(1) have adequate informal supports consisting of adult supervision that is present or available to contribute to care, or decision-making ability as documented on the UCAT~~,~~ Part III, to remain in his or her home without risk to his or her health, safety, and well-being, the individual:

(A) must have the decision-making ability to respond appropriately to situations that jeopardize his or her health and safety or available supports that compensate for his or her lack of ability as documented on the UCAT~~;~~ Part III; or

(B) who has his or her decision-making ability, but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and was informed by the DHS nurse of potential risks and consequences, may be eligible~~;~~.

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

(3) have a physical impairment or combination of physical and mental impairments as documented on the UCAT~~.~~ Part III. An individual who poses a threat to self or others as supported by professional documentation or other credible documentation may not be approved for Personal Care services. An individual who is actively psychotic or believed to be in danger of potential harm to self or others may not be approved for personal care services;

(4) not have members of the household or persons who routinely

visit the household who, as supported by professional documentation or other credible documentation, pose a threat of harm or injury to the individual or other household visitors;

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

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

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

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

(A) bathing;

(B) eating;

(C) dressing;

(D) grooming;

(E) transferring~~,~~ includes activities~~,~~ such as getting in and out of a tub~~,~~ or bed to chair;

(F) mobility;

(G) toileting; and

(H) bowel/bladder control.

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

(3) **"Consumer support very low need"** means the member's UCAT Part III Consumer Support score is zero (0) ~~that~~which indicates, in the UCAT Part III assessor's clinical judgment, the formal and informal sources are sufficient for present level of member need in most functional areas.

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

(5) **"Consumer support moderate need"** means the UCAT Part III Consumer score is ~~15~~fifteen (15) ~~that~~which indicates, in the UCAT Part III assessor's clinical judgment, the formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The member

requires additional assistance that usually includes personal care assistance with one or more ADLs not available through Medicare, the Veterans Administration, or other federal entitlement programs. Support provided by informal caregivers is of questionable reliability due to one (1) or more of the following:

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

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

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

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

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

(7) **"Community services worker"** means any non-licensed health professional employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities.

(8) **"Community Services Worker Registry"** means a registry established by the DHS, per Section (§) 1025.1 ~~et seq.~~ of Title 56 of the Oklahoma Statutes~~,~~ (O.S.) to list community services workers against whom a final investigative finding of abuse, neglect, or exploitation, per ~~Section 10-103 of Title 43A of the Oklahoma Statutes,~~43A O.S. § 10-103, involving a frail elderly, disabled person(s), or person(s) with developmental disabilities was made by DHS or an administrative law judge~~,~~; and amended in 2002, to include the listing of SoonerCare (Medicaid) personal care assistants (PCAs) providing personal care services.

(9) **"Instrumental activities of daily living (IADL)"** 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;~~phone;

(F) doing laundry;

(G) taking medication; and

(H) accessing transportation.

(10) **"IADLs score is at least six" (6)"** means the member needs some help with at least three (3) IADLs or cannot do two (2) IADLs at all.

(11) **"IADLs score of eight (8) or greater"** means the member needs some help with at least four (4) IADLs or the member cannot do two (2) IADLs at all and needs some help with one (1) or more other IADLs.

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

(13) **"MSQ moderate risk range"** means a total weighted-score of seven (7) to ~~11~~eleven (11) that indicates an orientation-memory-concentration impairment or memory impairment.

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

(15) **"Social resources score is eight (8) or more"** means the member lives alone or has no informal support when he or she is sick, needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for personal care.** The medical eligibility minimum criteria for personal care are the minimum UCAT Part III score criteria that a member must meet for medical eligibility for personal care and are:

(1) ADLs score is five (5) or greater; or IADLs score of eight (8) or greater; or Nutrition score is eight (8) or greater; or the MSQ score is seven (7) or greater; or the ADLs score is three (3) and IADLs score is at least six~~;~~ (6); and

(2) Consumer Support is ~~15~~fifteen (15) or more; or Consumer Support score is five (5) and the Social Resources score is eight or more.

(d) **Medical eligibility determination.** Medical eligibility for personal care is determined by the DHS. The medical decision for personal care is made by the DHS area nurse utilizing the UCAT~~.~~ Part III.

(1) Categorical relationship must be established for determination of eligibility for personal care. When categorical relationship to Aid to the Disabled was not established but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1. The licensed health care professional cannot be in a medical facility internship, residency, or fellowship program or in the full time employment of the Veterans Administration, United States Public Health Service, or other agency. The DHS county worker submits the

information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA) definition. A follow-up is required by the DHS county worker with (SSA) to ensure the SSA disability decision is also the LOCEU decision.

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

(3) Upon receipt of the referral, DHS county staff may initiate the UCAT, Part I.

(4) The DHS nurse is responsible for completing the UCAT Part III assessment visit within ~~10-business~~ten-business (10-business) days of the personal care referral for the applicant who is SoonerCare eligible at the time of the request. The DHS nurse completes the assessment visit within ~~20-business~~twenty-business (20-business) days of the referral for the applicant not determined SoonerCare eligible at the time of the request. When the UCAT Part I indicates the request is from an individual who resides at home and an immediate response is required to ensure the health and safety of the person, emergency situation, or to avoid institutional placement, the UCAT Part III assessment visit has top-scheduling priority.

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

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

(B) When multiple household members are applying for SoonerCare ~~Personal Care~~personal care services, the UCAT Part III assessment is done for all the household members at the same time.

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

(6) The DHS nurse completes the UCAT ~~within three-business days of the assessment visit~~Part III and sends it to the DHS area nurse for medical eligibility determination. Personal care service eligibility is established on the date medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) When the length of time from the initial assessment to the date of service eligibility determination exceeds ~~90-calendar~~ninety-calendar (90-calendar) days, a new UCAT Part III and assessment visit is required.

(B) The DHS area nurse assigns a medical certification period of not more than ~~36 months.~~thirty-six (36) months for persons eighteen (18) years of age and older or not more than twelve (12) months for persons younger than eighteen (18) years of age. The service plan period under the Service Authorization Model (SAM) is for a period of ~~12~~twelve (12) months and is provided by the DHS nurse.

(7) The DHS area nurse notifies the DHS county worker via ~~ELDERS~~Electronic Data Entry and Retrieval System (ELDERS) of the personal care certification. The authorization line is open via automation from ELDERS.

(8) Upon establishment of personal care certification, the DHS nurse contacts the member's preferred provider agency, or when necessary, the secondary provider agency or the provider agency selected by the round robin system. Within ~~one-business~~one-business (1-business) day of provider agency acceptance, the DHS nurse forwards the referral information to the provider agency for SAM plan development. Refer to OAC 317:35-15-8(a).

(9) Following the SAM packet development by the provider agency, and within ~~three-business~~three-business (3-business) days of receipt of the packet from the provider agency, the DHS nurse reviews the documentation to ensure agreement with the plan. Once agreement is established, the packet is authorized by the designee or submitted to the area nurse for review.

(10) Within ~~10-business~~ten-business (10-business) days of receipt of the SAM case from the DHS nurse, the DHS area nurse authorizes or denies the SAM units. If the SAM case fails to meet standards for authorization, the case is returned to the DHS nurse for further justification.

(11) Within ~~one-business~~one-business (1-business) day of knowledge of the authorization, the DHS nurse forwards the service plan authorization to the provider agency.

317:35-15-10. Redetermination of medical eligibility for personal care services

(a) **Medical eligibility redetermination.** The Oklahoma Department of Human Services (DHS) area nurse must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.

(b) **Recertification.** The DHS nurse re-assesses the personal care services member, eighteen (18) years of age and older, for medical re-certification based on the member's needs and level of caregiver support required, using the Uniform Comprehensive Assessment Tool (UCAT) Part III at least every ~~36~~thirty-six (36) months. Those members, who are younger than eighteen (18) years of age, are re-evaluated by the DHS nurse using the UCAT Part III on a twelve (12) month basis or sooner when needed. During this re-certification assessment, the DHS nurse informs the member of the state's other SoonerCare (Medicaid) long-term care options. The DHS nurse submits the re-assessment to the DHS area nurse for recertification. Documentation is sent to the DHS area nurse no later than the ~~10th-calendar~~tenth-calendar (10th-calendar) day of the month in which the certification expires. When the DHS area nurse determines medical eligibility for personal care services, a recertification review date is entered on the system.

(c) **Change in amount of units or tasks.** When the personal care provider agency determines a need for a change in the amount of units or tasks within the personal care service, a new Service Authorization Model (SAM) packet is completed and submitted to DHS within five~~-calendar~~ (5) business days of identifying the assessed need. The change is approved or denied by the DHS area nurse or designee, prior to implementation.

(d) **Voluntary closure of ~~Personal Care~~personal care services.** When a member decides personal care services are no longer needed to meet his or her needs, a medical decision is not needed. The member and the DHS nurse or DHS county Social Services Specialist completes and signs DHS Form 02AG038E, State Plan Personal Care/ADvantage Program Voluntary Withdrawal Request. The DHS nurse submits closure notification to the provider agency.

(e) **Resuming ~~Personal Care~~personal care services.** When a member approved for ~~Personal Care~~personal care services is without ~~Personal Care~~personal care services for less than ~~90 calendar-days~~ ninety-calendar (90-calendar) days but has current medical and SoonerCare (Medicaid) financial eligibility approval, ~~Personal Care~~personal care services may be resumed using the member's previously approved SAM packet. The personal care provider agency nurse contacts the member to determine when changes in health or

service needs occurred. When changes are identified, the provider agency nurse makes a home visit and submits a ~~Personal Care~~personal care services skilled nursing re-assessment of need within ~~10-business~~ten-business (10-business) days of the resumed plan start date, using the State Plan Personal Care Progress Notes, DHS Form 02AG044E. When the member's needs dictate, the ~~Personal Care~~personal care provider agency may submit a request for a change in authorized ~~Personal Care~~personal care services units with a SAM packet to DHS. When no changes occur, the agency nurse documents the contact on State Plan Personal Provider Communication Form 02AG032E and forwards it to the DHS nurse within ~~10-business~~ten-business (10-business) days of the resumed plan start date.

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

(g) **Closure due to medical ineligibility.** Individuals determined medically ineligible for ~~Personal Care~~personal care services are notified by DHS in writing of the determination and of their right to appeal the decision. When medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until level of care redetermination is established. For members:

(1) who are not hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for a maximum sixty-calendar (60-calendar)days from the date of the previous medical eligibility expiration date;

(2) who are hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for thirty-calendar (30-calendar) days from the date of discharge from the facility or for sixty-calendar (60-calendar) days from the date of previous medical eligibility expiration date, whichever is longer;

(3) whose medical eligibility redetermination is not made by applicable extended deadline, the member is determined to be no longer medically eligible; or

(4) who no longer meet medical eligibility or cannot be located to complete the redetermination assessment, the area nurse or nurse designee, updates the system's medical eligibility end date and notifies the DHS State Plan Care Unit (SPCU) nurse of effective end date. The DHS SPCU nurse submits closure notification to the provider agency.

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

services.

(1) Personal ~~Care~~care services may be discontinued when:

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

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

(C) the member or the other household members use~~:~~ threatening, intimidating, degrading, or sexually inappropriate language and/or innuendo or behavior towards service providers, either in the home or through other contact or communications; and efforts to correct such behavior were unsuccessful as supported by professional documentation or other credible documentation.

~~(i) angry, insulting, threatening, intimidating, degrading, or sexually inappropriate language; or~~

~~(ii) innuendos or behavior towards service provider, whether in the home or through other contact or communications; or~~

~~(iii) as supported by professional documentation or other credible documentation.~~

(D) the member or family member fails to cooperate with Personal Care service delivery or to comply with Oklahoma Health Care Authority (OHCA) or DHS rules as supported by professional documentation;

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

(F) additional services, either "formal" such as, paid by Sooner Care (Medicaid) or some other funding source or "informal" such as, unpaid are provided in the home eliminating the need for SoonerCare ~~Personal Care~~personal care services;

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

(H) the member refuses to select and/or accept the services of a provider agency or ~~PCA~~personal care assistant (PCA) for ~~90-consecutive~~ninety-consecutive (90-consecutive) days as supported by professional documentation.

(2) For persons receiving personal care services, the personal care provider agency submits documentation with the recommendation to discontinue services to DHS. The DHS nurse reviews the documentation and submits it to the DHS area nurse for determination. The DHS nurse notifies the personal care provider agency or PCA~~,~~ and the local DHS county worker of the

decision to terminate services. The member is sent an official closure notice informing him or her of appropriate member rights to appeal the decision to discontinue services.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-14. Case management services

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

(1) Within ~~one-business~~one-business (1-business) day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. The case manager makes a home visit to review the ADvantage program; its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and the Oklahoma Department of Human Services (DHS). The case manager will review~~;~~ and/or update~~ and complete~~ the Uniform Comprehensive Assessment Tool (UCAT)~~;~~ Part III and discuss service needs and ADvantage service providers. The ~~Case Manager~~case manager notifies the member's primary physician, identified in the UCAT ~~identified primary physician~~Part I, in writing that the member was determined eligible to receive ADvantage services. The notification is a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT~~.~~ Part III.

(2) Within ~~14-calendar~~fourteen-calendar (14-calendar) days of the receipt of an ADvantage referral, the case manager completes and submits~~ to the AA~~ a person-centered service plan~~ and service plan~~ for the member, signed by the member and the case ~~management supervisor.~~manager, to the case manager supervisor for approval and submission to the AA. The case manager completes and submits~~ to the AA~~ the annual reassessment person-centered service plan documents no sooner than ~~60-calendar~~sixty –calendar (60-calendar) days before the existing service plan ~~end date~~end-date but sufficiently in advance of the ~~end date~~end-date to be received by the AA at least ~~30-calendar~~thirty (30) days before the ~~end date~~end-date of the existing person-centered service plan. The case manager submits revisions for denied services to be resubmitted~~ to the AA~~ for approval within ~~5-business~~five-business (5-business) days~~.~~ to the AA. Within ~~14-calendar~~fourteen-calendar (14-calendar) days of receipt of a Service Plan Review~~ Request~~ (SPR) for short-term authorizations from the AA, the case manager ~~provides~~submits corrected person-centered service plan documentation. Within ~~five-business~~five-business (5-business) days of assessed need,

the case manager completes and submits a service plan addendum to the AA to amend current services on the person-centered service plan. The person-centered ~~and~~ service plan is based on the member's service needs identified by the UCAT Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for person-centered service plan development. Except for extraordinary circumstances, the IDT meetings are held in the member's home. ~~Variances from this policy must be presented to and approved by the AA in advance of the meeting.~~ When ~~in-home~~home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage ~~in-home~~home care ~~provider~~or assisted living provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, strengths and challenges ~~to~~for meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ADvantage case manager documents on the person-centered service plan~~,~~ the presence of two (2) or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. The case manager documents on the Electronic Visit Verification (EVV) system in the member record any instance in which a member's health or safety would be at risk when even one (1) personal care visit is missed. The case manager identifies services, service provider, funding source units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review/agreement with the person-centered service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian~~,~~ or legally authorized representative signs the person-centered service plan in the presence of the case manager. The signatures of two (2) witnesses are required when the member signs with a mark. When the member refuses to cooperate in development of the person-centered service ~~planor~~plan or when the member refuses to sign the person-centered service plan, the case management agency refers the case to the AA for resolution. ~~In addition based~~Based on the UCAT Part III and/or case progress notes that document chronic uncooperative or disruptive behaviors, the DHS nurse or AA may identify members that require AA intervention through referral to the AA's Escalated Issues unit.

(A) For members that are uncooperative or disruptive, the case manager ~~develops~~supports the member to develop an individualized person-centered service~~ individualized~~ plan to overcome challenges to receiving services. ~~focusing~~This plan focuses on behaviors, both favorable and those that

jeopardize the member's well-being and includes a design approach of incremental plans and ~~an~~ addenda that allows the member to achieve stepwise successes in behavior modification.

(B) The AA may implement a person-centered service plan without the member's signature when the presence of a document that requires their signature may itself trigger a conflict. In these circumstances, mental health/behavioral issues may prevent the member from controlling his or her behavior to act in his or her own interest. ~~The person~~When the member, by virtue of level of care and the IDT assessment, needs ADvantage services to ensure his or her health and safety, the AA may authorize the person-centered service plan when the case manager demonstrates effort to work with and obtain the member's agreement. Should negotiations not result in agreement with the person-centered service plan, the member may withdraw his or her request for services or request a fair hearing.

(4) Consumer-Directed Personal Assistance Services and Supports (CD-PASS) planning and supports coordination.

(A) ~~The ADvantage case management provider assigns the CD-PASS member a case manager that successfully completed training on CD-PASS, Independent Living Philosophy, Person-Centered Planning and the individual budgeting process and process guidelines. Case managers, who complete specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to his or her CD-PASS service planning and support role in working with CD-PASS members. The CDA/CM educates the member about his or her rights and responsibilities as well as community resources, service choices, and options available to the member to meet CD-PASS service goals and objectives.~~CD-PASS offers ADvantage members personal choice and control over the delivery of their in-home support service, including who provides the services and how services are provided. Members or their legal representatives have singular "employer authority" in decision-making and are responsible to recruit, hire, train, supervise and when necessary, terminate the individuals who furnish their services. They also have "budget authority" to determine how expenditures of their expense accounts are managed.

(B) ~~The member may designate a family member or friend as an authorized representative to assist in the service planning process and in executing member employer responsibilities. When 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 AA staff.~~Members who elect the CD-PASS service option receive support from Consumer-Directed Agent/Case Manager (CDA/CM) in directing their services. The CDA/CM liaison between the member and the program assists members, identifying potential requirements and supports as they direct their services and supports. ADvantage case management providers deliver required support and assign the CD-PASS members a case manager trained on the ADvantage CD-PASS service option, independent living philosophy, person centered service planning, the role of the member as employer of record, the individual budgeting process and service plan development guidelines. A case manager, who has completed specialized CD-PASS training, is referred to as a CDA/CM with respect to the service planning and support role when working with CD-PASS members. The CDA/CM educates the member about his or her rights and responsibilities as well as community resources, service choices and options available to the member to meet CD-PASS service goals and objectives.

~~(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 CD-PASS services to a member may not be designated the authorized representative for the member.~~

~~(iii) The case manager reviews the designation of authorized representative, power of attorney, and legal guardian status on an annual basis and includes this in the reassessment packet to AA.~~

(C) The ADvantage case management provider is responsible for ensuring that case managers serving members who elect to receive or are receiving the CD-PASS service option have successfully completed CD-PASS certification training in its entirety and have a valid CDA/CM certification issued by the AA.

(D) Consumer-directed, SoonerCare (Medicaid)-funded programs are regulated by federal laws and regulations setting forth various legal requirements with which states must comply. The ADvantage case management provider is responsible for ensuring that CDA/CMs in their employment provide services to CD-PASS members consistent with certification guidelines so as to be in keeping with federal, state, and Waiver requirements. Non-adherence may result in remediation for the case management provider, the case manager, or both, up to and including decertification.

(E) Members may designate a family member or friend as an authorized representative to assist in the service planning

process and in executing member employer responsibilities. When 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 AA staff.

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

(ii) An individual hired to provide CD-PASS services to a member may not be designated the authorized representative for the member.

(iii) The case manager reviews the designation of authorized representative, power of attorney, and legal guardian status on an annual basis and includes this in the reassessment packet to AA.

~~(C)~~(F) The CDA/CM provides support to the member in the ~~Person-Centered~~person-centered CD-PASS ~~Planning~~planning process. Principles of ~~Person-Centered Planning~~person-centered planning are listed in (i) through (v) of the subparagraph.

(i) The person is the center of all planning activities.

(ii) The member and his or her representative, or support team are given the requisite information to assume a controlling role in the development, implementation, and management of the member's services.

(iii) The individual and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals, and support needs.

(v) ~~Person-Centered Planning~~Person-centered planning results in personally-defined outcomes.

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

service plan.

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

~~(F)~~(I) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the person-centered service plan. The start date must be after:

(i) authorization of services;

(ii) completion and approval of the background checks; and

(iii) completion of the member employee packets.

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

~~(H)~~(K) When the plan requires an Advanced Personal Service Assistant (APSA) to provide assistance with health maintenance activities, the CDA/CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific health maintenance tasks safely and competently~~;~~, when the:

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

(ii)~~ when the~~ member and APSA attest that the APSA was performing the specific health maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two (2) months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

~~(I)~~(L) The CDA/CM monitors the member's well-being and the quality of supports and services and assists the member in revising the PSA services plan as needed. When the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the

CDA/CM, based upon an updated assessment, amends the person-centered service plan to modify CD-PASS service units appropriate to meet the additional ~~member's~~ need and ~~forwards~~submits the plan amendment to the AA for authorization and update of the member's IBA.

~~(J)~~(M) In the event of a disagreement between the member and CD-PASS provider the following process is followed:

(i) either party may contact via a toll free number the Member/Provider Relations Resource Center to obtain assistance with issue resolution;

(ii) when the issue cannot be resolved with assistance from the Member/Provider Relations Resource Center or from CD-PASS Program Management, the CD-PASS Program Management submits the dispute to the ADvantage Escalated Issues Unit for resolution. The Escalated Issues Unit works with the member and provider to reach a mutually-agreed upon resolution;

(iii) when the dispute cannot be resolved by the ADvantage Escalated Issues Unit it is heard by the Ethics of Care Committee. The Ethics of Care Committee makes a final determination with regard to settlement of the dispute; or

(iv) at any step of this dispute resolution process the member may request a fair hearing to appeal the dispute resolution decision.

~~(K)~~(N) The CDA/CM and the member prepare an emergency backup response capability for CD-PASS PSA/APSA services in the event a PSA/APSA services provider essential to the individual's health and welfare fails to deliver services. As part of the backup planning process, the CDA/CM and member define what failure of service or neglect of service tasks constitutes a risk to health and welfare to trigger implementation of the emergency backup (i) or (ii) may be used. Identification of:

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

(ii) ~~Identification of~~ one (1) or more qualified substitute ADvantage agency service providers, adult day health, personal care, or nursing facility (NF) respite provider, and preparation for quick response to provide backup emergency services.

~~(L)~~(O) To obtain authorizations for providers other than PSA and APSA identified as emergency backups, requests the AA authorize and facilitate member access to adult day health, agency personal care, or ~~Nursing Facility~~NF respite

services.

(5) The case manager submits the person-centered service plan to the case management supervisor for review. The case management supervisor ~~documents~~conducts the review/approval of the plans within two-business (2-business) days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected person-centered service plan to the case management supervisor within ~~two-business~~two-business (2-business) days. The case management supervisor returns the approved person-centered service plan to the case manager. Within ~~one-business~~one-business (1-business) day of receiving supervisory approval, the case manager ~~forwards,~~submits, ~~by United States mail, a legible copy of~~ the person-centered service plan to the AA. ~~Case managers are responsible for retaining all original documents for the member's file at the agency.~~ Only priority service needs and supporting documentation may be ~~faxed~~submitted to the AA ~~with the word, "PRIORITY" clearly indicated and the~~as a "Priority" case with justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the NF. Corrections to service conditions set by the AA are not considered a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a NF.

(6) Within ~~one-business~~one-business (1-business) day of notification of care plan and person-centered service plan authorization, the case manager communicates with the service plan providers and member to facilitate service plan implementation. Within ~~five-business~~five-business (5-business) days of notification of an initial person-centered service plan or a new reassessment service plan authorization, the case manager visits the member, gives the member a copy of the person-centered service plan ~~or computer-generated copy of the person-centered service plan,~~ and evaluates the service plan implementation progress. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within ~~30-calendar~~thirty-calendar (30-calendar) days of the authorized effective date of the person-centered service plan or service plan addendum amendment; and

(B) monthly after the initial ~~30-calendar~~thirty-calendar (30-calendar) follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans**. The AA authorizes the individual person-centered service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, service plan cost

~~effectivenessfor~~effectiveness for service providers that are ADvantage authorized and SoonerCare contracted, and that the delivery of ADvantage services are consistent with the member's level of care need, the service plan is authorized.

(1) Except as provided by the process per ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-761(6), family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member, such as the spouse or parent of a minor child.

(2) ~~The~~ DHS AS may, per OAC 317:35-15-13, authorize personal care service provision by an Individual PCA, an individual contracted directly with OHCA. Legally responsible family members are not eligible to serve as Individual PCAs.

(3) When ~~the~~a complete service plan authorization or amendment request ~~packet~~is received ~~from case management is complete~~ and the service plan is within cost-effectiveness guidelines, the AA authorizes or denies authorization within five-business (5-business) days of receipt of the request. When the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the member to access services in an alternate setting or program. When the request packet is ~~not complete,~~incomplete, the AA notifies the case manager immediately and puts a hold on authorization until the ~~required additional documents~~requirements are received from case management.

(4) The AA authorizes the service plan by entering the authorization date ~~and assigning a control number that internally identifies the DHS staff completing the authorization~~. Notice of authorization ~~and a computer-generated copy of the authorized plan or a computer-generated copy~~ of the ~~authorized~~service plan ~~are provided to case management.~~is available through the appropriate designated software or web-based solution. AA authorization determinations are provided to case management within one-business (1-business) day of the authorization date. A person-centered service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval within ~~5-business~~five-business (5-business) days.

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

a request to the member's case manager.

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

(1) The service provider initiates the process for an increase or decrease in service to the member's person-centered service plan. The requested changes and justification are documented by the service provider and, when initiated by a direct care provider, are submitted to the member's case manager. When in agreement, the case manager ~~requests~~submits the service changes ~~on a service plan amendment submitted to the AA~~ within five-business (5-business) days of the assessed need. The AA authorizes or denies the person-centered service plan changes, per ~~Oklahoma Administrative Code (OAC)~~OAC 317:35-17-14.

(2) The member initiates the process for replacing ~~Personal Care~~personal care services with ~~Consumer-Directed Personal Services and Supports (CD-PASS)~~CD-PASS in geographic areas where CD-PASS services are available. The member may contact the AA or call the toll-free number to process requests for CD-PASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour (4-hour) or more adjustment in services per week, requires an updated UCAT Part III reassessment by the case manager. The case manager develops an amended or new person-centered service plan, as appropriate, and submits the new amended person-centered service plan for authorization.

(4) One (1) or more of the following changes or service requests require an Interdisciplinary Team review and service plan goals amendment:

(A) the presence of two (2) or more ADvantage members residing in the same household;

(B) the member and personal care provider residing together;

(C) a request for a family member to be a paid ADvantage service provider; or~~.~~

(D) a request for an individual PCA service provider.

(5) Based on the reassessment and consultation with the AA as needed, the member may, as appropriate, be authorized for a new person-centered service plan or be eligible for a different service program. When the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated signature indicating voluntary withdrawal for ADvantage program services. When unable to obtain the member's consent for voluntary closure, the case manager requests ~~(AA)~~AA assistance. The AA requests that the DHS area nurse initiate a reconsideration of level of care.

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

317:35-17-22. Billing procedures for ADvantage services

(a) Billing procedures for long-term care medical services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the Oklahoma Health Care Authority (OHCA).

(b) The Oklahoma Department of Human Services (DHS) Aging Services (AS) approved ADvantage service plan is the basis for the Medicaid Management Information Systems (MMIS)service prior authorization, specifying~~:~~ the:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin- and ~~end dates~~end-dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits are used to evaluate if paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims not supported by service plan authorization and/or documentation of service provision are turned over to the OHCA ~~Provider Audit~~Clinical Provider Audits Unit for follow-up investigation.

(d) All contracted providers for ADvantage Waiver services must submit billing to the State Medicaid agency, Soonercare using the appropriate designated software, or web-based solution to submit all claims transactions. When the designated system is unavailable, contracted providers submit billing directly to OHCA.

~~(d)~~(e) Service time of personal care, case management, case management for transitioning, nursing, advanced supportive/restorative assistance, in-home respite, consumer-directed personal assistance services and supports (CD-PASS), personal services assistance, and advanced personal services assistance is documented solely through the Electronic Visit Verification System (EVV)~~ also known as Interactive Voice Response Authentication (IVRA) system,~~ when provided in the home. Providers are required to use the EVV system. The EVV system provides alternate backup solutions when the automated system is unavailable. In the event of EVV system failure, the provider documents time in accordance with internal policy and procedures. This documentation suffices to account for in-home and office services delivered. Provider agency backup procedures are only

permitted when the EVV system is unavailable.

~~(e)~~(f) The provider must document the amount of time spent for each service, per Oklahoma Administrative Code (OAC) 317:30-5-763. For service codes that specify a time segment in their description, such as ~~15~~fifteen (15) minutes, each timed segment equals one (1) unit. Only time spent fulfilling the service for which the provider is authorized, per OAC 317:30-5-763 is authorized for time-based services. Providers do not bill for a unit of time when not more than one-half of a timed unit is performed~~. For example~~, such as, when a unit is defined as ~~15~~fifteen (15) minutes, providers do not bill for services performed for less than eight (8) minutes. The rounding rules utilized by the EVV and web-based billing system to calculate the billable unit-amount of ~~are,~~care, services provided for duration of:

(1) less than ~~8-minutes~~eight-minutes (8-minutes) cannot be rounded up and do not constitute a billable ~~15-minute~~fifteen-minute (15-minute) unit; and

(2) ~~8 to 15~~eight (8) to fifteen (15) minutes are rounded up and do constitute a billable ~~15-minute~~fifteen-minute (15-minute) unit.

(g) Providers required to use EVV must do so in compliance with OAC 317:30-3-4.1, Uniform Electronic Transaction Act (UETA). Providers must ensure:

(1) an established process is in place to deactivate an employee's access to EVV or designated system records upon termination of employment of the designated employee;

(2) safeguards are put in place to ensure improper access or use of EVV or designated system is prohibited and sanctions will be applied for improper use or access by staff;

(3) that staff providing or delivering in-home personal care services must use the EVV system for checking-in and checking out when providing services;

(4) staff delivering personal-care services is trained in the use of the EVV system;

(5) a record of services delivered is maintained;

(6) that staff confirms in writing that they will use the system as they are trained or directed;

(7) that staff will access the system using their assigned personal identification number (PIN) for in-home service delivery;

(8) staff accessing EVV or other designated systems for billing, properly use the authentication features of the system to properly document work and confirm work that is submitted for billing for services that were rendered;

(9) procedures as outlined in the UETA pertaining to electronic signatures, will be applied at such time when use of the electronic signatures is approved and applicable for necessary transaction;

(10) the EVV or other designated system is responsible for retention of all records that are associated with and generated for the purpose of claims and billing submitted for payment of services rendered;
(11) that they produce and enforce a security policy that outlines who has access to their data and what transactions employees are permitted to complete as outlined; and
(12) when using EVV or other designated system for billing and claims submissions, each new invoice or claim, must include the following information in (i) through (vi). The:
(i) type of service performed;
(ii) individual receiving the services;
(iii) date of the service;
(iv) location of service delivery;
(v) individual providing the service; and
(vi) time the service begins and ends.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-2. Nursing Facility (NF) program medical eligibility determination

The ~~DHS~~Oklahoma Department of Human Services (DHS) area nurse or nurse designee, determines medical eligibility for ~~nursing facility (NF)~~NF services based on the ~~long term care (LTC)~~DHS nurse's Uniform Comprehensive Assessment Tool ~~(UCAT III)~~(UCAT) Part III assessment of the client's needed level of care, the outcome of the Level II Preadmission Screening and Resident Review (PASRR), when completed, and his or her professional judgment. The Oklahoma ~~Healthcare~~Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) makes some determinations when the ~~(PASRR)~~PASRR is involved. Refer to Oklahoma Administrative Code (OAC) 317:35-19-7.1(3) for ~~nursing facility~~NF level of care medical eligibility requirements.

(1) When NF care services are requested prior to admission, the same rules related to medical eligibility determination identified in OAC 317:35-17-5 for ADvantage services are followed.

(2) The ~~LTC~~DHS nurse reviews the PASRR Level I in the ~~Oklahoma Health Care Authority~~OHCA system; completes the UCAT III; and enters the date OHCA received the PASRR Level I (LTC-300R) from the NF and admission date to the NF; ~~financial~~medical eligibility effective date and notes any Level II PASRR results if available in the UCAT Part III. This information is submitted to the DHS ~~Area Nurse~~area nurse for medical eligibility determination.

(3) PASRR requirements are identified in OAC 317:35-19-8 and 317:35-19-9.

(4) When it is not possible for the UCAT Part III assessment to be completed prior to admission, the NF is responsible for notifying the DHS of the admission. Notification is mailed or faxed on DHS Form 08MA083E, Notification ~~regarding~~Regarding Patient In A Nursing Facility, Intermediate Care Facility for the ~~Mentally Retarded~~Intellectually Disabled or Hospice, and Management Recipient Funds to the local DHS county office. Upon receipt, the DHS county office processes~~ Forms 08MA084E and 08MA084EForms~~ Forms 08MA083E and 08MA084E and completes and forwards the Form 08MA038E, Notice Regarding Financial Eligibility to the NF. Identified sections of the UCAT Part III reflecting the domains for meeting medical criteria are completed for applicants residing in the NF at the time of assessment. The area nurse or nurse designee, confirms the date of medical eligibility and records it in the system. The facility is responsible for performing the PASRR Level I screen and consulting with OHCA staff to determine when a need exists for a Level II screen. The ~~LTC~~DHS nurse ~~conducts~~completes the assessment~~ visit~~ within ~~15-business~~fifteen-business (15-business) days of PASRR clearance when the individual's needs are included in an active DHS coded case. When the individual's needs are not included in an active case, the assessment is ~~conducted~~completed within ~~20-business~~twenty-business (20-business) days of PASRR clearance.

(5) The area nurse or nurse designee, evaluates the PASRR Level I screen and the UCAT Part III in consultation with the DHS nurse when the completed LTC-300R and/or facility documentation shows a need exists for a possible Level II screen. The area nurse or nurse designee consults with OHCA staff as necessary.

(6) The area nurse or nurse designee, evaluates the UCAT Parts I and III, to determine if the applicant meets the medical eligibility criteria for NF level of care. Individuals may be medically-certified for NF level of care for various lengths of time depending on the client's needs. The area nurse or nurse designee, enters the medical eligibility decision and, when required, the medical certification review date into Aging Services Division Electronic Data Entry and Retrieval System (ELDERS) within ~~10-business~~ten-business (10-business) days. A medical eligibility redetermination is not required when a client is discharged from the NF for a period not to exceed ~~90-calendar~~ninety-calendar (90-calendar) days and the original certification is current.

(7) When the ~~LTC~~DHS nurse recommends NF level of care and the client is determined by the area nurse or nurse designee, not to be medically eligible for NF level of care, the ~~LTC~~DHS nurse can submit additional information to the area nurse or nurse designee. When necessary, a visit by the ~~LTC~~DHS nurse to obtain additional information is initiated at the recommendation of

the area nurse or nurse designee.
(8) Categorical relationship must be established for determination of eligibility for NF services. When categorical relationship to disability has not been established, the worker submits the same information, per OAC 317:35-5-4(2) to the LOCEU to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship to the disabled applicant using the Social Security Administration (SSA) definition. A follow-up with the SSA by the DHS worker is required to ensure the SSA disability decision agrees with the LOCEU decision.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and Community-Based Services Waivers (HCBS) for persons with intellectual disabilities or certain persons with related conditions

(a) **Introduction to HCBS ~~Waivers~~waivers for persons with intellectual disabilities.** The Medicaid ~~Home and Community-Based Services (HCBS)~~HCBS ~~Waiver~~waiver programs are authorized~~ in accordance with~~per Section 1915(c) of the Social Security Act.

(1) Oklahoma Department of Human Services Developmental Disabilities Services Division ~~(DDSD)~~(DDS) operates HCBS ~~Waiver~~waiver programs for persons with intellectual disabilities and certain persons with related conditions. The Oklahoma Health Care Authority (OHCA), ~~as~~is the State's~~ single~~ Medicaid agency, retains and exercises administrative authority over all HCBS ~~Waiver~~waiver programs.

(2) Each waiver allows for the provision of specific SoonerCare-compensable services that assist members to reside in the community and avoid institutionalization.

(3) ~~Waiver~~HCBS waiver services:

(A) complement and supplement services available to members through the Medicaid State Plan or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) ~~can~~are only~~ be~~ provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution;~~ and~~

(C) are not intended to replace other services and supports available to members~~.~~; and

(D) are authorized based solely on current need.

(4) ~~Any waiver service~~HCBS waiver services must be:

(A) appropriate to the member's needs; and

(B) included in the member's Individual Plan (IP).

(i) The IP:

(I) is developed annually by the member's Personal Support Team, per ~~OAC~~Oklahoma Administrative Code (OAC) 340:100-5-52; and

(II) contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

(ii) Services are authorized, ~~in accordance with~~per OAC 340:100-3-33 and 340:100-3-33.1.

(5) ~~DDSD~~DDS furnishes case management, targeted case management, and services to members as a Medicaid State Plan ~~service under~~services, per Section 1915(g)(1) of the Social Security Act ~~in accordance with~~and per OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with an intellectual disability or related conditions.

(1) All providers, except pharmacy, specialized medical supplies and durable medical equipment providers must be reviewed by ~~OKDHS DDSD.~~DHS DDS. The review process verifies~~:~~ that:

(A) the provider meets the licensure, certification or other standards ~~as~~ specified in the approved HCBS ~~Waiver~~waiver documents; and

(B) organizations that do not require licensure ~~wishing~~wanting to provide HCBS services meet program standards, are financially stable and use sound business management practices.

(2) Providers who do not meet ~~the~~program standards in the review process ~~will~~are not ~~be~~ approved for a provider agreement.

(3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

(c) **Coverage.** All services must be included in the member's IP~~. Arrangements for services must be made with~~ and arranged by the member's case manager.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-5. ~~Community-Based Services~~Community-based services

~~Community-Based Services~~Community-based services are provided in sites and at times typically used by others in the community and promote independence, ~~inclusion within the~~ community~~,~~ inclusion, and the creation of natural supports. Community-based services must reflect the member's choice and values in typical age and cultural situations~~ that are typical for age and culture~~.

(1) Approved ~~Community-Based Services~~community-based services are individualized work-related supports targeting inclusion into integrated experiences~~. Community-Based Services~~ and are pre-planned, documented activities supported by a schedule relating to the member's identified employment outcomes. Approved community-based services activities include:

(A) active participation in formalized volunteer activities;

(B) active participation in paid or unpaid work experience sites in community settings;

(C) training through generic entities such as trade schools, ~~Vo Techs,~~technology centers, ~~junior~~community colleges, or other community groups. The provider is paid for the time ~~during which~~when direct supports are necessary and provided;

(D) stamina-enhancing programs~~ that occur~~ in integrated settings;

(E) transportation to and from employment or community-based activities;

(F) meals and breaks~~ which must occur~~ during~~ the conduct of~~ the member's employment activities~~;~~ that occur in the community at a location used for the same purpose, with others without disabilities;

(G) job tours or job shadowing scheduled with and provided by a ~~community business~~community-business entity;

(H) using Workforce OK services; and

(I) attending job fairs.

(2) Any other work-related, community-based activities must be approved through the exception process, ~~described in OAC~~ per Oklahoma Administrative Code (OAC) 317:40-7-21.

(3) ~~Community-Based Services~~Community-based services continue ~~if~~when the member ~~has to go~~goes to a center-based facility for support, such as repositioning or personal care, as long as the member returns immediately to a planned community-based activity. The amount of time for the repositioning and personal care are based upon a Team-approved health care positioning plan~~ approved by the Team~~.

(4) ~~Community-Based Services~~Community-based services are available for individual and group placements.

(A) Individual placement means the member is provided supports that enable him or her to participate in ~~approved~~individual community-based activities described in this Section~~ individually~~ and not as part of a group placement.

(B) Group ~~Placement~~placement means ~~two to five~~two-to-five members are provided supports that enable ~~him or her to participate~~participation in the approved community-based activities described in this Section.

317:40-7-6. Center-based services

(a) Center-based services are~~ any~~ employment ~~service~~services provided where ~~a~~the majority of the people at the site ~~are persons with a disability.~~have disabilities. These settings facilitate opportunities to seek employment in competitive settings and support access to the greater community.

(b) Center-based services are pre-planned, documented activities that relate to the member's identified employment outcomes.

(c) Examples of ~~Center-based~~center-based services are active participation in:

(1) learning and work experiences where the individual can develop general, non-job-task specific strengths and skills that contribute to employability in paid employment in integrated community settings;

(2) team-prescribed therapy programs, such as speech, physical therapy, or a switch activation program implemented by employment provider staff in the workshop or other center-based setting;~~ and~~

(3) computer classes, General Education Development preparation, job club, interviewing skills, or other classes ~~whose~~where all participants~~ all~~ have disabilities, even when the location is in the community~~.~~; and

(4) mealtimes where the majority of people with disabilities are employed.

(d) Paid contract work is usually subcontracted, and the ~~persons~~member receiving services ~~earn~~earns commensurate wage according to Department of Labor regulations.

(e) Participation in ~~Center-based~~center-based services is limited to ~~15~~fifteen (15) hours per week for ~~persons~~members receiving services through the Homeward Bound Waiver, unless approved through the exception process, ~~explained in (OAC)~~per Oklahoma Administrative Code (OAC) 317:40-7-21.

(f) The provider agency must meet physical plant expectations, ~~of (OAC)~~per OAC 340:100-17-13.

(g) During periods in which no paid work is available~~ for members,~~ despite the provider's documented good faith efforts to secure

work, the employment-provider agency ensures each member participates in training activities that are age appropriate, work related, and consistent with the Individual Plan. Such activities may include, but are not limited to:

(1) resume development and application writing;
(2) work attire selection;
(3) job interview training and practice;
(4) job safety and evacuation training;
(5) personal or social skills training; and
(6) stamina and wellness classes.

317:40-7-15. Service requirements for employment services through Home and Community-Based Services (HCBS) Waivers

(a) The Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) case manager, the member, ~~a~~the member's family or, when applicable, the member's legal guardian, and the member's provider develop a preliminary plan of services including the:

(1) site and amount of the services ~~to be~~ offered;
(2) types of services to be delivered; and
(3) expected outcomes.

(b) To promote community integration and inclusion, employment services are only delivered in non-residential sites.

(1) Employment services through ~~Home and Community-Based Services (HCBS) Waivers~~HCBS waivers cannot be reimbursed when those services occur in the member's or paid staff's residence or property ~~of the member or provider-paid staff~~, including garages and sheds, ~~whether the garage or shed is~~when attached or unattached to the home ~~or not~~. When a home-based business is established and supported through the Oklahoma Department of Rehabilitation Services (OKDRS), DDS stabilization services are utilized when OKDRS stabilization services end.

(2) No exceptions to Oklahoma Administrative Code (OAC) 317:40-7-15(b) are authorized.

(c) The service provider is required to notify the DDS case manager in writing when the member:

(1) is placed in a new job;
(2) loses his or her job. A ~~Personal Support Team~~personal support team (Team) meeting must be held when the member loses the job;
(3) experiences significant changes in the community-based or employment schedule; or
(4) ~~experiences other circumstances,~~is involved in critical and non-critical incidents per OAC 340:100-3-34.

(d) The provider submits a DHS Provider Progress Report, per OAC 340:100-5-52, for each member receiving services.

(e) The cost of a member's employment services, excluding transportation and state-funded services per OAC 340:100-17-30, cannot exceed $27,000 per Plan of Care year.
(f) Each member receiving ~~residential supports per OAC 340:100-5-22.1, or group home services is employed for 30 hours per week or receives a minimum of 30 hours of employment services, each week, excluding transportation to and from the member's residence.~~HCBS is supported in opportunities to seek employment and work in competitive integrated settings. When the member is not employed in a competitive integrated job, the Team identifies outcomes and/or action steps to create opportunities that move the member toward competitive integrated employment.
(g) Each member receiving residential supports, per OAC 340:100-5-22.1, or group-home services is employed for thirty (30) hours per week or receives a minimum of thirty (30) hours of employment services each week, excluding transportation to and from his or her residence.

(1) ~~Thirty-hours~~Thirty (30) hours of employment service each week may be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, ~~and~~or job coaching services. Center-based services cannot exceed ~~15~~fifteen (15) hours per week for members receiving services through the Homeward Bound Waiver.

(2) ~~Less than 30 hours of employment activities per week requires approval per OAC 317:40-7-21.~~When the member does not participate in thirty (30) hours per week of employment services, the Team:

(A) documents the outcomes and/or action steps to create a pathway that moves toward employment activities;

(B) describes a plan to provide a meaningful day in the community; or

(C) increases the member's employment activities to thirty (30) hours per week.

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in ~~OAC~~Oklahoma Administrative Code (OAC) 317:40-7 are:

(1) approved, per OAC 317:40-7-21 prior to service implementation;

(2) intended to result in the ~~Personal Support Team~~personal support team (Team) development of an employment plan tailored to meet the member's needs;

(3) identified in the Individual Plan (Plan) process, per OAC 340:100-5-50 through 340:100-5-58; and

(4) documented and recorded in the Individual Plan by the Developmental Disabilities Services Division ~~(DDSD)~~(DDS) case manager after Team approval.

(b) ~~A request for an exception to the minimum of 30 hours per week of employment services, per OAC 317:40-7-15, includes documentation of the Team's:~~

~~(1) discussion of:~~

~~(A) current specific situation that requires an exception;~~

~~(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and~~

~~(C) progress toward previous exception strategies or plans;~~

~~(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and~~

~~(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.~~

~~(c)~~ A request for an exception to the maximum limit of ~~15~~fifteen (15) hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

(A) a current, specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan, with specific steps and target dates to address the situation throughout the Plan of Care year, so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

~~(d)~~(c) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan, with specific steps and target dates to address the situation throughout the Plan of Care year, so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

~~(e)~~(d) Exception requests, per OAC 340:40-7-21~~(f)~~(e), are documented by the ~~DDSD~~DDS case manager after Team consensus, and submitted to the ~~DDSD area manager~~DDS field administrator or designee within ~~ten working~~ten (10)-business days after the annual IP or interim Team meeting. The ~~area manager~~field administrator approves or denies the request ~~with a copy to the DDSD area office claims staff and case manager~~ based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives. A copy of the field administrator's decision is provided to the assigned case manager. A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(1) a current, specific situation that requires an exception;

(2) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(3) progress toward previous exception strategies or plans.

~~(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:~~

~~(A) Team's discussion of current specific situation that requires an exception;~~

~~(B) specific medical issues necessitating the exception request; and~~

~~(C) a projection of units needed to complete the State fiscal year.~~

~~(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:~~

~~(A) current specific situation that requires an exception;~~

~~(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and~~

~~(C) progress toward previous exception strategies or plans.~~

~~(f)~~(e) The ~~DDSD~~DDS director or designee may review exceptions granted per OAC 317:40-7-21, directing the Team to provide additional information, ~~if~~when necessary, to comply with OAC 340:100-3-33.1 and other applicable rules

Drug Utilization Review Board – Drug Summary

Recommendation	Drug	Used for	Cost*	Notes
1	**Jivi®**	Hemophilia A	$26,280 - $35,040 per 4 weeks of prophylaxis therapy	
	Hemlibra®	Hemophilia A with or without inhibitors	$29,316.00 - $35,179.20 per 4 weeks of prophylaxis	
	Feiba®	Hemophilia A or B with an inhibitor	$123,879.00 per 4 weeks of prophylaxis therapy	
	NovoSeven® RT	Hemophilia A or B with an inhibitor, congenital factor VII deficiency, Glanzmann's thrombasthenia, or acquired hemophilia	$20,800 - $31,200 per bleeding episode for hemophilia A or B	A bleeding episode may require additional doses which will increase the cost

*Costs do not reflect rebated prices or net costs. Costs based on Specialty Pharmaceutical Allowable Cost (SPAC) or Wholesale Acquisition Costs (WAC).

Recommendation: Vote to Prior Authorize Jivi® [Antihemophilic Factor (Recombinant), PEGylated-aucl], Hemlibra® (Emicizumab-kxwh), Feiba® (Anti-Inhibitor Coagulant Complex), and NovoSeven® RT [Coagulation Factor VIIa (Recombinant)]

The OHCA recommends the prior authorization of Jivi® [antihemophilic factor (recombinant) PEGylated-aucl], Hemlibra® (emicizumab-kxwh), Feiba® (anti-inhibitor coagulant complex), and NovoSeven® RT [coagulation factor VIIa (recombinant)]with the following criteria:

Jivi® [antihemophilic factor (recombinant) PEGylated-aucl] Approval Criteria:

1. An FDA approved indication; and
2. Requested medication must be prescribed by a hematologist specializing in rare bleeding disorders or a mid-level practitioner with a supervising physician that is a hematologist specializing in rare bleeding disorders; and
3. A patient-specific, clinically significant reason why the member cannot use the following:
    a. Hemophilia A: Advate® or current factor VIII replacement product; or
    b. Hemophilia B: Benefix® or current factor IX replacement product; and
4. A half-life study must be performed to determine the appropriate dose and dosing interval; and
5. Initial approvals will be for the duration of the half-life study. If the half-life study shows significant benefit in prolonged half-life, subsequent approvals will be for the duration of one year.

Hemlibra® (Emicizumab-kxwh) Approval Criteria:

1. Member must have a diagnosis of hemophilia A; and
2. Hemlibra® must be prescribed by a hematologist specializing in rare bleeding disorders or a mid-level practitioner with a supervising physician that is a hematologist specializing in rare bleeding disorders; and
3. Prescriber must be able to monitor appropriate blood clotting tests and levels utilizing testing which accounts for the interaction of Hemlibra® and blood factors by following the Medical and Scientific Advisory Council (MASAC) guidance; and
4. For members with hemophilia A with an inhibitor to factor VIII:
    a. Member must have failed immune tolerance induction (ITI) or is not a good candidate for ITI; and
    b. Member's hemophilia cannot be managed without the use of bypassing agent(s) (e.g., Feiba®, NovoSeven® RT) as prophylaxis for prevention of bleeding episodes, or the member is unable to maintain venous access for daily infusions; and

    c. Member's hemophilia is not currently controlled with the use of bypassing agent(s); and
    d. Prescriber must council member and/or caregiver on the risks of utilizing Feiba® for breakthrough bleeding while on Hemlibra®, and member should be monitored closely if any bypassing agent is given; or
5. For members with hemophilia A without an inhibitor:
    a. Member's current prophylaxis therapy is not adequate to prevent spontaneous bleeding episodes, or the member is unable to maintain venous access for prophylactic infusions; and
    b. Treatment plan must be made to address breakthrough bleeds and procedures; and
    c. Routine lab screening must occur for factor VIII inhibitor while using Hemlibra® since this would change the treatment plan for bleeds and procedures; and
6. First dose must be given in a health care facility; and
7. In order to calculate appropriate dosing, the member's recent weight must be provided and have been taken within the last 3 months.
8. Initial approvals will be for 3 months of therapy. Subsequent approvals will be the duration of 1 year if there has been a decrease in the member's spontaneous bleeding episodes since beginning Hemlibra® treatment.

Feiba® (Anti-Inhibitor Coagulation Complex) Approval Criteria:

1. Member must be diagnosed with hemophilia A or B with an inhibitor; and
2. Feiba® must be prescribed by a hematologist specializing in rare bleeding disorders or a mid-level practitioner with a supervising physician that is a hematologist specializing in rare bleeding disorders.

NovoSeven® RT [Coagulation Factor VIIa (Recombinant)] Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Hemophilia A or B with inhibitors; or
    b. Congenital factor VII deficiency; or
    c. Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets; or
    d. Acquired hemophilia; and
2. NovoSeven® RT must be prescribed by a hematologist specializing in rare bleeding disorders or a mid-level practitioner with a supervising physician that is a hematologist specializing in rare bleeding disorders.