Oklahoma Health Care Authority MEDICAL ADVISORY COMMITTEE March 6th, 2025 1:00 – 3:00 PM Charles Ed McFall Board Room

AGENDA

Please access via zoom:

https://www.zoomgov.com/webinar/register/WN cRW1L6K6ThyiNvzUiwulDw

Telephone: 1-669-254-5252 Webinar ID: 160 297 4109

- I. Welcome, Roll Call, and Public Comment Instructions: Chairman, Jason Rhynes, O.D.
- II. Action Item: Approval of Minutes of January 9th, 2025: Medical Advisory Committee Meeting
- III. Public Comments (2 minute limit)
- IV. MAC Member Comments/Discussion
- V. Financial Reports: Josh Richards, Senior Director of Financial Services
- VI. <u>SonerSelect Marketing Plans:</u> Christina Foss, Chief of Staff
- VII. Prior Authorizations: Paula Root, Chief Medical Officer
- VIII. Change of Service Provision Updates: Sandra Puebla, Deputy State Medicaid Director
- IX. <u>Proposed Rule Changes: Presentation, Discussion, and Vote:</u> Kasie McCarty, Senior Director of Federal and State Authorities
 - A. APA WF # 25-02 A&B ADvantage Waiver Policy Revisions
 - B. APA WF # 25-05 Nursing Facility Durable Medical Equipment (DME) Revision
 - C. APA WF # 25-03 SoonerSelect Policy Revisions
- X. <u>New Business:</u> Chairman, Jason Rhynes, O.D.
- XI. <u>Future Meeting:</u> Chairman, Jason Rhynes, O.D.

May 1, 2025 July 10, 2025 September 11, 2025 November 6, 2025

XII. Adjourn Chairman, Jason Rhynes, O.D.

I. Welcome, Roll Call, and Public Comment Instructions:

Co-Chairperson, Ms. Wanda Felty called the meeting to order at 1:03 PM.

Delegates present were: Dr. Nick Barton, Ms. Joni Bruce ,Mr. Brett Coble, Mr. Tracy Ellis, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Jennifer King, Ms. Melissa Miller, Dr. J. Daniel Post, Dr. Marny Dunlap and Dr. Jason Rhynes providing a quorum.

Alternates present were: Dr. Eve Switzer

Delegates absent without an alternate were: Dr. Raymond Smith, and Dr. Whitney Yeates.

II. Approval of November 7th, 2024, Minutes

Medical Advisory Committee

The motion to approve the minutes was by Ms. Joni Bruce by Dr. Jason Rhynes and passed unanimously.

III. Public Comments (2-minute limit):

There were no public comments.

IV. MAC Member Comments/Discussion:

Dr. Crawford asked for an update regarding the OHCA policy on Molecular testing for upper respiratory illnesses. Dr. Root responded, stating that we have done a query on some of the surrounding states, and what their guidelines are. Some of the states do have similar criteria to us, but not all states. Our guidelines were updated October 1st and they're all the same for clinics, hospitals, labs, and any outpatient setting. It will cover for the higher risk of complications from influenza or RSV. If the member is admitted and in the hospital those guidelines don't apply to hospitals, so that all the testing can be done while the member is admitted. There is a budget impact to expanding coverage, so we are in the talks with our finance department. Dr. Root will be following up with our updated diagnosis lists.

Dr. Switzer made an observation that when updating their dental list in Enid they previously stated they had 6 offices and now it shows only 2. Traylor asked Dr. Switzer to email a list of those clinics he will reach out to our two dental plans to do outreach.

Dr. Post stated his staff's hatred for the credentialing process and trying to get visits approved. As he has been on the committee for 20 years, he has never been invited to make any recommendations, or comments, or see how the process works. Dr. Post has asked to see how chiropractors are

involved, and how claims have been paid, how many patients have been able to access chiropractic care. Dr. Post is frustrated with the lack of response and wants his comment known.

Dr. Rhynes stated that HB1979 was passed, and children are receiving their eyeglasses within 2 days instead of weeks. OHCA also completed their study of the 6 surrounding Oklahoma states and their reimbursement process and found that it was significantly lower, and we could double the price and still be in range.

Ms. Wanda Felty had one statement regarding the DDS waivers. Under self-directed services the family can set a rate. The family doesn't have to bill at the highest rate the state allows, they can stair-step it, allowing for entry level position to start at lower rates. One of the issues is that a family cannot have two different staff work the same day at two different rates because of the billing system. She requests OHCA investigate this to allow a different billable rate.

V. Financial Reports:

Josh Richards, Senior Director of Financial Services

Mr. Richards presented the financial report ending in October 2024. OHCA is 2.1% under budget in revenues and 3.3% under budget in expenditure with the result that our budget variance is a positive \$36,732.529. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 1.6 million state dollars, and administration is 103.1 million state dollars. For more detailed information, see agenda item 5 in the MAC agenda.

VI. <u>Legislative Update:</u>

Christina Foss, Chief of Staff

Ms. Foss stated that the session starts on February 3rd. Not all bills have been filed yet with their language, so we don't have a current tracking list. We have 2 carryover bills from last session, one was modernizing our nursing facility, reimbursement, & methodology, the other establishes a paid family caregiver model that we will be hearing again. One of our request bills will clarify the regulatory bodies between us and the insurance department when we're talking about regulating our Medicaid managed care plans. Another bill is adding 2 spots to the MAC. Last is what we call our EGID cleanup bill.

VII. Change of Service Provision:

Sandra Puebla, Deputy State Medicaid Director

Ms. Puebla stated that in September Aetna Better Health of Oklahoma (ABHOK) submitted a formal request to OHCA for review and approval to change service provisions. OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and

practices, standard business practice in other markets, and available data to determine whether to approve the requests. OHCA approved the proposed modification allowing available information on file to be reviewed to validate the billed and/or derived DRG by clinically reviewing all billed diagnosis and procedure codes submitted on a claim. In November Oklahoma Complete Health and Oklahoma Complete Health Children's Specialty Program submitted a formal request to implement a prior authorization requirement for all tonsillectomies/adenoidectomies performed on patients over 12 years of age, which OHCA approved. Lastly, in November, Oklahoma Complete Health and Oklahoma Complete Health Children's Specialty Program also submitted a request to add cumulative refill too soon logic, which was also approved.

VIII. Medicaid Directors Update:

Traylor Rains, State Medicaid Director

Mr. Rains started by acknowledging the OHCA as a recipient in the transforming maternal health grant along with 13 other states. This will bring about 17 million dollars into the state over a 10-year period, with the first 3 years in the planning phase. Mr. Rains wants to congratulate Folake and her team for their hard work and implementation. As a notice, this is Mr. Rains' last meeting with the MAC, as he has accepted a position in the private sector.

A. Transition in Value base payment:

Folake Adedeji, Chief Quality Officer

Dr. Adedeji talked about what a value base payment program is, defining it as an arrangement/agreement/contract between entities to align value and costs. Simple types of VBP arrangements include paying for reporting, and performance/pay for quality. More complex types of VBP arrangements include upside, and downside risks. OHCA VBP program is a quality withhold program, which will withhold a percentage of the CEs' capitation payments annually. All CEs VBP programs will launch January 1st, 2025. PCMH care coordination payments will continue through June 30th, 2025. For more detailed information, see item 8a in the MAC agenda.

VIII. Proposed Rule Changes: Presentation, Discussion, and vote:

Kasie McCarty, Senior Director of Federal and State Authorities

A. APA WF # 24-11 Doula Certifying Organization Criteria — The proposed policy includes OHCA-developed minimum criteria that doula certifying organizations must meet to be State recognized. The proposed criteria address doula specialty certifications offered by the organization, frequency of recertification, training modalities, support experience

required and references for prospective doulas, and practice guidelines and standards (including ethics guidelines and a grievance/disciplinary policy). OHCA will only contract with doulas who are certified by a recognized certifying organization meeting the minimum criteria.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

B. APA WF # 24-13 Program of All-Inclusive Care for the Elderly (PACE) Policy – The proposed rule changes clarify the PACE organization's responsibilities in addressing housing insecurity for a potential or current participant, requirements of the involuntary disenrollment process, and participant use of assisted living.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

C. APA WF # 24-17A&B Electronic Visit Verification (EVV) Revisions — Proposed revisions align agency policy with the 21st Century Cures Act by requiring the use of EVV by home health agencies. Live-in caregivers are added as a provider for personal care services and must also adhere to EVV requirements. Additionally, language is updated to reflect the name change for Oklahoma Human Services and the department who oversee the program.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

D. APA WF # 24-28 Crisis Intervention Services Limitations — The OHCA, in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), will update crisis intervention policy to match current business practice. Hard limits on these services will be removed from policy to ensure that all members who utilize crisis intervention services have adequate treatment.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

E. APA WF # 24-29 Diagnosis Clarification for Inpatient Psychiatric Services — Proposed policy revisions remove autism spectrum disorder (ASD) and intellectual disability (ID) as primary presenting diagnoses for admission into inpatient psychiatric services. A diagnosis of ASD or ID cannot be exclusionary and may be present and documented as coexisting with other qualifying conditions for admission as the secondary diagnosis. The primary presenting diagnosis must be consistent with the primary reason for admission. These changes shall not be used to preclude or exclude any member with ASD or ID.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

F. APA WF # 24-30 Updates to Residential Substance Use Disorder (SUD) Policy — OHCA, in collaboration with ODMHSAS, proposes modifications to residential SUD policies which currently requires physician supervision for American Society of Addiction Medicine (ASAM) level 3.7 of care. This update allows for RN supervision and adds licensed independent practitioners (physician, APRN, and PA) as providers of this level of care. Changes clarify the time frame for assessments and progress notes, when service plans and reviews are valid, the signature requirements, and removes specific assessment tool terminology for adolescents.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

G. APA WF 24-31 A&B Removal of Outdated Language — OHCA is updating policy to replace outdated terminology with "individuals with intellectual disabilities" or "intellectual disability."

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

H. APA WF # 24-32 Removing Certain Drugs from 340b Program — These rule revisions seek to remove certain drugs and therapies from the 340b Drug Pricing Program. The 340b program is a federal initiative that allows health care organizations to purchase certain drugs directly from pharmaceutical manufacturers at a discount. One restriction on this program is that no rebates can be collected from any drug or therapy purchased under the program, including supplemental rebates. These revisions prohibit purchasing drugs under the 340b program if they are in a supplemental rebate agreement.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

I. APA WF # 24-33 In Lieu of Service or Setting (ILOS) — Proposed revisions align policy with the Managed Care Access, Finance, and Quality Final Rule as it relates to an ILOS. Revisions add the definition of an ILOS when provided by a managed care contracted entity (CE) as a substitute for a covered service or setting under the state plan. Additionally, an ILOS must be approvable as a service or setting through a 1915(c) Home and Community Based Service waiver or a state plan amendment. Policy revisions also clarify that an approved ILOS is a component of the capitation rate paid to SoonerSelect CEs.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

IX. New Business:

Chairman, Jason Rhynes, O.D.

There was no new business addressed.

X. Adjourn:

Chairman, Jason Rhynes, O.D.

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Arlen Foulks and seconded by Dr. Steven Crawford, there was no dissent and the meeting adjourned at 3:25pm.



FINANCIAL REPORT

For the Five Month Period Ending November 30, 2024 Submitted to the CEO & Board

- Revenues for OHCA through November, accounting for receivables, were \$3,482,141,310 or 2.7% under budget.
- Expenditures for OHCA, accounting for encumbrances, were \$3,539,060,011 or 3.9% under budget.
- The state dollar budget variance through November is a positive \$45,781,456.
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Administration	1.8
Medicaid Program Variance	140.4
Revenues: Federal Funds Drug Rebate Medical Refunds Taxes and Fees	(90.9) (8.9) 6
Taxes and rees	(2.6)
Total FY 25 Variance	\$ 45.8

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA	1
Medicaid Program Expenditures by Source of Funds	2
Other State Agencies Medicaid Payments	3
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Combining Statement of Revenue, Expenditures and Fund Balance	7
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Summary of Administrative Expenditures: OHCA	9

OKLAHOMA HEALTH CARE AUTHORITY Summary of Revenues & Expenditures: OHCA SFY 2025, For the Five Months Period Ending November 30, 2024

ENUES		FY 25 Budget YTD		FY 25 Actual YTD		Variance	% Over (Under
State Appropriations	\$	535,475,900	\$	535,475,900	\$	_	0
Federal Funds	Ψ	2,488,517,720	Ψ	2,397,550,092	Ψ	(90,967,627)	(3.
						, , ,	
Tobacco Tax Collections		16,273,291		16,114,950		(158,342)	(1.
Quality of Care Collections		44,068,540		41,000,755		(3,067,785)	(7
Prior Year Carryover		59,076,671		59,076,671		-	(
Federal Deferral - Interest		261,646		261,646		-	(
Drug Rebates		226,340,810		217,442,505		(8,898,305)	(3
Medical Refunds		21,773,552		27,763,407		5,989,855	2
Prior Year Carryover Supplemental Hospital Offset Payment Program		, -,		, , . <u>-</u>		-	
Supplemental Hospital Offset Payment Program		184,537,057		184,691,989		154,933	
Other Revenues		, ,					
Other Revenues		2,311,454		2,763,396		451,941	1
TOTAL REVENUES	\$	3,578,636,640	\$	3,482,141,310	\$	(96,495,330)	(2
		FY 25		FY 25			% (Ove
ENDITURES		Budget YTD		Actual YTD		Variance	Unde
ADMINISTRATION - OPERATING	\$	27,742,487	\$	25,957,489	\$	1,784,998	
ADMINISTRATION - CONTRACTS	\$	74,936,762	\$	74,888,982	\$	47,780	
MEDICAID PROGRAMS							
Managed Care:							
SoonerCare Choice		15,684,099		16,683,826		(999,727)	(6
SoonerSelect Medical		822,484,583		745,054,353		77,430,230	`
SoonerSelect Dental		61,754,169		58,168,132		3,586,037	
SoonerSelect DPP - Provider Incentives		27,981,501		12,900,891		15,080,610	5
SoonerSelect CSP		60,791,046		63,414,005		(2,622,960)	(4
		, . ,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		()=	`
Acute Fee for Service Payments:		405 040 004		460,879,272		04 460 040	
Hospital Services		485,040,084				24,160,812	
Behavioral Health		10,659,359		6,974,132		3,685,226	3
Physicians		140,674,017		110,027,368		30,646,648	2
Dentists		24,632,883		27,260,138		(2,627,255)	(10
Other Practitioners		13,601,091		14,578,471		(977,380)	(7
Home Health Care		13,623,513		14,396,780		(773,267)	(5
Lab & Radiology		11,866,096		8,260,641		3,605,455	3
Medical Supplies		34,131,667		34,137,131		(5,463)	(0
Ambulatory/Clinics		171,148,635		183,143,664		(11,995,028)	(7
Prescription Drugs		374,543,760		383,864,050		(9,320,290)	(2
OHCA Therapeutic Foster Care		195,587		(10,042)		205,629	10
·		100,007		(10,012)		200,020	
Other Payments: Nursing Facilities		388,207,751		389,509,717		(1,301,966)	(0
· ·						, ,	,
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private		40,189,821		38,446,988		1,742,833	
Medicare Buy-In		82,076,127		82,027,086		49,041	
Transportation		61,160,642		46,005,394		15,155,248	2
Money Follows the Person-OHCA		660,925		695,289		(34,364)	(5
Electronic Health Records-Incentive Payments		(391)		(391)		-	
Part D Phase-In Contribution		53,641,651		53,108,675		532,977	
Supplemental Hospital Offset Payment Program		678,586,207		683,685,038		(5,098,831)	(0
Telligen		5,233,343		5,002,932		230,411	(0
Total OHCA Medical Programs		3,578,568,166		3,438,213,540		140,354,625	
OHCA Non-Title XIX Medical Payments		89,382		-		89,382	10
TOTAL OHCA	\$	3,681,336,797	\$	3,539,060,011	\$	142,276,786	;

Total Medicaid Program Expenditures by Source of State Funds SFY 2025, For the Five Months Period Ending November 30, 2024

Category of Service	Total	Health Care Authority	Quality of Care	Insure Oklahoma	SHOPP	всс	Other State Agencies
SoonerCare Choice	16,683,826	16,683,406	¢	\$ -	\$ -	\$ 419 \$	<u> </u>
SoonerSelect Medical	878,155,613	745,054,353		·	\$ -		
SoonerSelect Dental	58,168,132	58,168,132	Ψ -	Ψ -	Ψ -	Ψ - 4	100,101,200.20
SoonerSelect DPP - Provider Incentives	12,900,891	12,900,891	\$ -	\$ -	\$ -	\$ - 9	
SoonerSelect CSP	63,414,005	63,414,005		\$ -		\$ - 9	
Inpatient Acute Care	517,831,680	279,470,537	202,786	(92)	•	44,611	125,333,544
Outpatient Acute Care	223,844,181	180,871,677	17,335	(156)		272,326	120,000,044
Behavioral Health - Inpatient	29,019,150	4,449,334	-	(100)	4,724,728	-	19,845,088
Behavioral Health - Psychiatrist	4,567,714	2,524,798	_	_	2,042,916	<u>-</u>	-
Behavioral Health - Outpatient	6,467,418	2,02 1,7 00	_	_	2,012,010	_	6,467,418
Behavioral Health-Health Home	-	_	_	_	_	_	-
Behavioral Health Facility- Rehab	65,057,118	_	_	_	_	847	65,057,118
Behavioral Health - Case Management	1,131,943	_	_	_	_	-	1,131,943
Behavioral Health - PRTF	3,782,617	_	_	_	_	_	3,782,617
Behavioral Health - CCBHC	80,998,242	_					80,998,242
Residential Behavioral Management	912,307	_	_	_	_	_	912,307
Targeted Case Management	19,435,119	_	_	_	_	_	19,435,119
Therapeutic Foster Care	(10,042)	(10,042)	_	_	_	_	10,400,110
Physicians	161,130,338	109,822,526	24,209	(121)	_	180,634	51,103,090
Dentists	27,260,138	27,256,340	24,200	(121)	_	3,798	-
Mid Level Practitioners	69,684	69,684	_	_	_ _	5,750	_
Other Practitioners	14,508,788	14,319,043	185,985	_	_	3,760	_
Home Health Care	14,396,780	14,396,264	100,000	_	_	517	_
Lab & Radiology	8,260,641	8,257,852	_	_	_	2,789	_
Medical Supplies	34,137,131	33,005,217	1,129,805	_	_	2,109	_
Clinic Services	187,156,080	180,030,428	1,120,000	_	_	24,746	7,100,906
Ambulatory Surgery Centers	3,088,490	3,086,628	_	_	_	1,862	7,100,000
Personal Care Services	4,611,961	-	_	_	_	-	4,611,961
Nursing Facilities	389,509,717	269,384,968	120,124,749	_	_	_	-,011,001
Transportation	45,908,647	44,671,090	1,158,425	_	_	79,132	_
IME/DME	42,776,627		1,100,420	_	_	70,102	42,776,627
ICF/IID Private	38,446,988	32,659,105	5,787,883	_	_	_	
ICF/IID Public	6,859,991	02,000,100	0,707,000				6,859,991
CMS Payments	135,135,761	134,923,480	- 212,281	-	-	-	0,059,991
Prescription Drugs	383,863,709	383,684,295	212,201	(341)	-	- 179,755	-
Miscellaneous Medical Payments	96,747	96,747	-	(341)	-	179,733	-
Home and Community Based Waiver	140,469,286	90,747	-	-	-	-	140,469,286
Homeward Bound Waiver	34,863,806	-	-	-	-	-	34,863,806
Money Follows the Person	2,481,514	695,289	-	-	-	-	1,786,225
In-Home Support Waiver	34,333,600	093,289	-	-	-	-	34,333,600
ADvantage Waiver	130,514,067	-	-	-	-	-	130,514,067
Family Planning/Family Planning Waiver	386,029	-	-	-	-	-	386,029
Premium Assistance*	10,889,686	-	-	10,889,686	-	-	300,029
Directed Payments	521,454,101	-	-	10,009,000	521,454,101	-	-
•	5,002,932	5,002,932	-	-	52 1,454, IU I	-	-
Telligen Electronic Health Records Incentive Payments	5,002,932	5,002,932	-	-	-	-	-
Total Medicaid Expenditures	1 /	\$ 2,624,888,587	\$ 128 842 459	\$ 10,888,976	\$ 683,685,038	¢ 707.205	910.970.242
rotal wedicald Expenditures	\$ 4,359,972,759	3 2,624,888,58 /	\$ 128,843,458	\$ 10,888,976	\$ 683,685,038	\$ 797,305	910,870,242

^{*} Includes \$10,825,104.34 paid out of Fund 245

Summary of Revenues & Expenditures: Other State Agencies

SFY 2025, For the Five Months Period Ending November 30, 2024

REVENUE

FY 25 Actual YTD

EVENUE		Actual TTD
Revenues from Other State Agencies		312,604,01
Federal Funds		647,470,16
TOTAL REVENUES	\$	960,074,17
(PENDITURES		Actual YTD
Oklahoma Human Services		Actual 11D
	¢	140 460 29
Home and Community Based Waiver	\$	140,469,28
Money Follows the Person		1,786,22
Homeward Bound Waiver		34,863,80
In-Home Support Waivers		34,333,60
Advantage Waiver		130,514,06
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		6,859,99
Personal Care		4,611,96
Residential Behavioral Management		464,31
Targeted Case Management		17,238,69
Total Oklahoma Human Services		371,141,93
		0,, .
State Employees Physician Payment		
Physician Payments Total State Employees Physician Payment		51,103,09
Total State Employees Physician Payment		51,103,09
Education Payments		
Indirect Medical Education		41,427,11
Direct Medical Education		1,349,51
DSH Total Education Payments		42,776,62
Total Education Payments		42,770,02
Office of Juvenile Affairs		
Targeted Case Management		197,93
Residential Behavioral Management		447,99
Total Office of Juvenile Affairs		645,92
Department of Mental Health & Substance Abuse Services		
Case Management		1,131,94
Inpatient Psychiatric Free-standing		19,845,08
Outpatient		6,467,41
Health Homes		
Psychiatric Residential Treatment Facility		3,782,61
Certified Community Behavioral Health Clinics		80,998,24
Rehabilitation Centers		65,057,11
SoonerSelect		133,101,26
Total Department of Mental Health & Substance Abuse Services		310,383,68
State Department of Health		
Children's First		79,28
Sooner Start		,
Health Clinics		464,55
		•
Early Intervention		914,52
Early and Periodic Screening, Diagnosis, and Treatment Clinic		118,30
Family Planning		94,68
Family Planning Waiver		290,05
Maternity Clinic		16,30
Total Department of Health		1,977,70
County Health Departments		
EPSDT Clinic		9,30
		•
Family Planning Waiver		1,29
Total County Health Departments		10,60
State Department of Education		264,88
Public Schools		739,81
Medicare DRG Limit		104,592,06
Native American Tribal Agreements		6,492,43
_		
Department of Corrections JD McCarty		3,391,26 17,350,2
		, ,
Total OSA Medicaid Programs	\$	910,870,24
OSA Non-Medicaid Programs	\$	44,540,10
Accounts Receivable from OSA	\$	(4,663,82
Accounts Receivable from USA		(4,003,82
D 0		

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund SFY 2025, For the Five Months Period Ending November 30, 2024

REVENUES	FY 25 Revenue	
SHOPP Assessment Fee	184	1,421,378
Federal Draws	\$ 517	7,449,914
Interest		270,612
Penalties		-
TOTAL REVENUES	\$ 702	2,141,903

- 9/30/23 ,674,703 ,398,409 ,566,648 677,400 ,961,764 ,653,413	10/1/23 - 12/31/23 37,674,703 14,398,409 1,566,648 677,400 77,961,764 70,653,413 2,549,415	1/1/24 - 3/31/24 - - - -	4/1/24 - 6/30/24 - \$ - \$ - \$ - \$ - \$	75,349,40 29,796,81 3,133,29 1,354,80 155,923,52
,398,409 ,566,648 677,400 ,961,764 ,653,413	14,398,409 1,566,648 677,400 77,961,764 70,653,413	- - -	- \$	29,796,81 3,133,29 1,354,80
,566,648 677,400 ,961,764 ,653,413	1,566,648 677,400 77,961,764 70,653,413	- - -	- \$	29,796,81 3,133,29 1,354,80
677,400 ,961,764 ,653,413	677,400 77,961,764 70,653,413	-	- \$	1,354,80
,961,764 ,653,413	77,961,764 70,653,413	-	- \$	• •
,653,413	70,653,413		•	155.923.52
				,-=-,
,549,415	2 5/19 //15		- \$	141,306,82
	2,343,413		- \$	5,098,83
,351,201	4,351,201		- \$	8,702,40
,588,198	12,588,198		- \$	25,176,39
-	-		- \$	
,715,444	18,715,444	-	- \$	37,430,8
,679,627	6,206,554	-	- \$	12,886,1
795,716	795,716	-	- \$	1,591,4
344,058	344,058	-	- \$	688,1
,080,527	43,080,527		- \$	86,161,0
,542,532	49,542,532	-	- \$	99,085,0
			\$	
579.055	341.105.983			683,685,0
	,351,201 ,588,198 ,715,444 ,679,627 795,716 344,058 ,080,527 ,542,532	12,588,198 - 18,715,444 18,715,444 18,679,627 795,716 344,058 19,080,527 19,542,532 12,588,198 12,588,198 12,588,198 12,588,198 18,715,444 18,715,444 19,206,554 795,716 344,058 43,080,527 49,542,532	12,588,198	1,588,198 - - \$ 1,715,444 18,715,444 - - \$ 1,679,627 6,206,554 - - \$ 795,716 795,716 - - \$ 344,058 344,058 - - \$ 1,080,527 43,080,527 - - \$ 1,542,532 49,542,532 - - \$

^{***} Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund SFY 2025, For the Five Months Period Ending November 30, 2024

REVENUES	Total Revenue			State Share
			\$	-
Quality of Care Assessment	\$	40,972,757	\$	40,972,757
Quality of Care Penalties (*Non-Spendable Revenue)	\$	60,060	\$	60,060
Interest Earned	\$	27,998	\$	27,998
TOTAL REVENUES	\$	41,060,816	\$	41,060,816

XPENDITURES		FY 25 Total \$ YTD	Ş	FY 25 State \$ YTD	S	Total State \$ Cost
Program Costs						
Nursing Facility Rate Adjustment	\$	118,658,916	\$	38,743,557		
Eyeglasses and Dentures		110,753	\$	36,162		
Personal Allowance Increase		1,355,080	\$	442,418		
Coverage for Durable Medical Equipment and Supplies		1,129,805	\$	368,881		
Coverage of Qualified Medicare Beneficiary		430,315	\$	140,498		
Part D Phase-In		212,281	\$	212,281		
ICF/IID Rate Adjustment		2,003,390	\$	654,070		
Acute Services ICF/IID		3,784,493	\$	1,235,717		
Non-emergency Transportation - Soonerride		1,158,425	\$	378,247		
NF Covid-19 Supplemental Payment		-	\$, -		
ICF Covid-19 Supplemental Payment		_	\$	-		
Ventilator NF DME Supplemental Payment			\$	_		
Total Program Costs	\$	128,843,458	\$	42,211,830	\$	42,211,830
Administration						
OHCA Administration Costs	\$	131,952	\$	65,976		
OHS-Ombudsmen	·	, -		, -		
OSDH-Nursing Facility Inspectors		_		-		
Mike Fine, CPA		_		_		
Total Administration Costs	\$	131,952	\$	65,976	\$	65,976
Total Quality of Care Fee Costs	\$	128,975,410	\$	42,277,806		
TOTAL STATE SHARE OF COSTS					\$	42,277,806

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

SUMMARY OF REVENUES & EXPENDITURES:

Insure Oklahoma Program (Fund 245: HEEIA)

SFY 2025, For the Five Months Period Ending November 30, 2024

REVENUES	(FY 24 Carryover				FY 25 Revenue	Total Revenue
Prior Year Balance	\$	1,411,645					
State Appropriations		-					
Federal Draws - Prior Year		113,167					
Total Prior Year Revenue					1,524,812		
Transfer to 340 for Expansion-current year				-	-		
Tobacco Tax Collections		-		13,253,979	13,253,979		
Interest Income		-		37,329	37,329		
Federal Draws		-		7,666,907	7,666,907		
TOTAL REVENUES	\$	1,524,812	\$	20,958,215	22,483,027		

ENDITURES		FY 2 Expendi		E	FY 25 xpenditures	Total State \$ YTD
Program Costs:	Employer Sponsored Insurar College Students/ESI Dental			\$	10,825,104 64,581	\$ 10,825,104 21,093
Individual Plan						
	SoonerCare Choice Inpatient Hospital Outpatient Hospital BH - Inpatient Services-DRG BH -Psychiatrist Physicians Dentists Mid Level Practitioner Other Practitioners Home Health Lab and Radiology Medical Supplies Clinic Services Ambulatory Surgery Center Skilled Nursing Prescription Drugs Transportation Premiums Collected			\$	- (92) (156) - - (121) - - - - - - (341) -	\$ (3) (5) - (3) - - - - - - (11)
Total Individual Plan	. romanie Genedica			\$	(710)	\$ (23
	College Students-Service (Costs		\$	-	\$
Total OHCA Program	Costs			\$	10,888,976	\$ 10,845,96
Administrative Costs						
	Salaries Operating Costs E&E Development Gainwell	\$	(0) 141	\$	609,305 562	\$ 609,30 70
	Contract - Gainwell	18	39,915		287,292	477,20
Total Administrative (Costs	\$ 19	0,055	\$	897,159	\$ 1,087,21
Total Expenditures						\$ 11,933,18
Transfer to Fund 340	for Expansion Costs					\$ 8,590,23
NET CASH BALANCE		\$ 1,33	84,757	\$	624,859	\$ 1,959,61

Combining Statement of Revenues, Expenditures and Changes in Fund Balance SFY 2025, For the Five Months Period Ending November 30, 2024

	Administration Fund 200	Supplemental Hospital Offset Payment Program Fund 205	Quality of Care Fund 230	Rate Preservation Fund 236	Federal Deferral Fund 240	Health Employee and Economy Act Fund 245	Belle Maxine Hilliard Breast & Cervical Cancer Treatment (Tobacco) Fund 250	Medicaid Program (Tobacco) Fund 255	Ambulance Service Provider Access Payment Program Fund 270	Medicaid Program Fund 340		Total Cash Balance
	T dila 200	r drid 200	1 dila 200	T dila 200	240	Tuna 240	T dild 200	T dild 200	T dild 210	T drid 545	10075	Total Gasii Balance
NOVEMBER Beginning Fund Balan	ice:											
Prior year	52,409,552	6,179,367	15,275	495,678,835	18,456,928	1,334,757	-	-	-	479,010,659	155,271,038	1,208,356,411
Current year	(10,922,636)	5,833,759	436,485	33,333,332	207,323	728,074	-	-	-	(219,190,190)	2,306,097	(187,267,754)
Total	41,486,917	12,013,127	451,760	529,012,167	18,664,251	2,062,831	-	-	-	259,820,469	157,577,136	1,021,088,657
NOVEMBER Revenues:												
Prior year	1,136,543	-	-	-	-	-	-	-	-	13,421,494	-	14,558,038
Current year	16,137,898	104,046	7,416,419	-	54,322	4,117,879	52,522	3,147,245	1,028,594	663,668,400	107,328,347	803,055,671
Total	17,274,441	104,046	7,416,419	-	54,322	4,117,879	52,522	3,147,245	1,028,594	677,089,894	107,328,347	817,613,708
NOVEMBER Expenditures:												
Prior year	1,782,117	-	-	-	-	-	-	-	-	-	-	1,782,117
Current year	16,325,810	-	-	-	-	2,194,894	-	-	-	682,102,268	-	700,622,972
Total	18,107,927	-	-	-	-	2,194,894	-	-	-	682,102,268		702,405,089
Operating Transfers In Prior year												
Current year	6,474,328	-	-	8,333,333	-	-	-	-	-	115,736,738	-	130,544,398
Total	6,474,328	-	-	8,333,333	-	-	-	-	-	115,736,738	-	130,544,398
Account Receivables	111,814	(535,526)	-						-	40,276,510		39,852,798
	111,814	(535,526)	-	-	-	-	-	-	-	40,276,510	-	39,852,798
Operating Transfers Out												
Prior year	4,020,721	_	_	-	_	_	_	_	_	11,583,333		15,604,054
Current year	-	-	7,868,179	-	-	1,718,046	52,522	3,147,245	1,028,594	-	155,271,038	169,085,624
Total	4,020,721	-	7,868,179	-	-	1,718,046	52,522	3,147,245	1,028,594	11,583,333	155,271,038	184,689,678
Change in CY Fund Balance	(4,636,220)	5,937,805	(15,275)	41,666,665	261,646	933,013		-	-	(121,887,321)	(45,636,594)	(123,376,280)
Ending Fund Balance	42,995,224	12,652,698	-	537,345,500	18,718,574	2,267,770	-	-	-	318,684,989	109,634,445	1,042,299,199

OKLAHOMA HEALTH CARE AUTHORITY HEALTHY ADULT PROGRAM EXPENDITURES - OHCA SFY 2025, For the Five Months Period Ending November 30, 2024

	FY 25 BUDGETED EXPENDITURES		FY 25 ACTUAL EXPENDITURES	BUDGET VARIANCE (Over)/
NOVEMBER Beginning Fund Balance:	Full Year	Year to Date	NOVEMBER	Under
OHCA MEDICAID PROGRAMS				
Managed Care				
SoonerCare Choice	744,566	310,236	302,170	8,066
SoonerSelect Medical	803,761,870	329,965,300	308,610,350	21,354,950
SoonerSelect Dental	38,506,682	15,830,730	15,774,870	55,861
Total Managed Care	843,013,118	346,106,266	324,687,391	21,418,876
Fee for Service				
Hospital Services:				
Inpatient Acute Care	151,971,955	69,135,523	57,714,810	11,420,713
SHOPP - DPP	370,492,235	185,246,117	185,246,117	-
SHOPP - FFS	58,263,548	32,446,187	52,596,617	(20,150,430)
Outpatient Acute Care	110,255,040	49,303,294	54,269,610	(4,966,316
Total Hospitals	690,982,777	336,131,122	349,827,154	(13,696,033)
Behavioral Mental Health:				
Inpatient Services - DRG	10,897,419	5,122,718	6,627,663	(1,504,945)
Outpatient	-	- -	· · · · · · · · · · · · · · · · · · ·	-
Total Behavioral Mental Health	10,897,419	5,122,718	6,627,663	(1,504,945)
Physicians & Other Providers:				
Physicians	71,100,511	32,013,150	25,512,961	6,500,189
Dentists	9,781,932	4,136,279	4,370,607	(234,328)
Mid-Level Practitioner	57,708	24,415	25,489	(1,074
Other Practitioners	7,649,348	3,457,027	3,717,616	(260,590
Home Health Care	289,599	127,819	116,921	10,898
Lab & Radiology	9,356,944	3,983,877	2,294,004	1,689,873
Medical Supplies	7,767,915	3,492,255	2,954,664	537,591
Clinic Services	96,145,109	43,218,956	45,878,801	(2,659,845
Ambulatory Surgery	2,121,472	940,790	655,222	285,568
Total Physicians & Other Providers	204,270,538	91,394,566	85,526,284	5,868,282
Misc Medical & Health Access Network	8,141	3,821	58,043	(54,222
Transportation	20,187,251	8,472,618	7,713,790	758,828
Health Access Network	-	-	56,515	(56,515)
Provider Incentive Program	34,978,798	11,104,953	-	11,104,953
Prescription Drugs	290,521,155	125,313,431	122,807,226	2,506,205
Total OHCA Medicaid Programs	2,094,859,198	923,649,496	897,304,067	26,345,430

MAC PRESENTATION

Paula Root MD, MPH, MBA
Chief Medical Officer, Sr. Medical Director
Oklahoma Health Care Authority



PRIOR AUTHORIZATION REQUEST

PRIOR AUTHORIZATION REQUEST

CPT 65778 will require a Prior Authorization (PA) effective March 17, 2025 CPT 65778: placement of amniotic membrane on the ocular surface, without sutures

- Human amniotic membrane (AM) graft is placed over the ocular surface without using glue or sutures
- AM may be used to promote healing of ocular surface conditions that have the potential to create corneal scarring, or are not responding to treatment
- These conditions include various types of keratitis, corneal ulcers, neurotrophic keratopathy, and chemical burns

PRIOR AUTHORIZATION REQUEST

Affected Providers are:

- Optometrists
- Ophthalmologists

PRIOR AUTHORIZATION REQUEST

Full authorization guidelines can be found on the OKHCA.org MAU webpage



GET IN TOUCH

4345 N. Lincoln Blvd. Oklahoma City, OK 73105 oklahoma.gov/ohca mysoonercare.org Agency: 405-522-7300 Helpline: 800-987-7767









SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that medical contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On January 29, 2025, Humana Healthy Horizons in Oklahoma (HHH) submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the request, evaluating it in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the requests.

OHCA decisions are noted in the table below:

SoonerSelect Medical Requests to Change Service Provisions				
PROCEDURE CODE(S) IMPACTED	OHCA'S CURRENT CLAIMS PROCESSING PROTOCOL	PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTCOL	ANTICIPATED IMPACT	OHCA DECISION
Claims ER Evaluation	on and Management	(E/M) Policy Expansion	on	
Current Procedural Terminology (CPT) codes 99281-99285 And Healthcare Common Procedure Coding System (HCPCS) codes G0380-G0384 in conjunction with an applicable revenue code.	OHCA does not offer an ER EM Leveling Program today. However, providers currently bill revenue code 45x with the appropriate CPT code and the claim prices off the APC table.	For reimbursable services, Humana will compare facility charges for Evaluation and Management (E/M) services provided in emergency departments against defined criteria. When the facility's billed ER E/M service code is higher than what is supported by the criteria for that code, Humana will reimburse at the lower E/M service code based on meeting defined	Projected Net Savings is estimated at \$2.2M Estimated \$107K in annual savings for CAH (critical access hospitals)	APPROVED

SoonerSelect Medical Requests to Change Service Provisions				
PROCEDURE CODE(S) IMPACTED	OHCA'S CURRENT CLAIMS PROCESSING PROTOCOL	PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTCOL	ANTICIPATED IMPACT	OHCA DECISION
		criteria for the lower code.		



SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that medical contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On December 6, 2024, Aetna Better Health of Oklahoma submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the requests.

OHCA decisions are noted in the table below:

SoonerSelect Medical Requests to Change Service Provisions					
PROCEDURE CODE(S) IMPACTED	OHCA'S CURRENT CLAIMS PROCESSING PROTOCOL	PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTCOL	ANTICIPATED IMPACT	OHCA DECISION	
Implementation of	PA Requirements for	Specific Codes			
<u>Cardioversion</u> <u>Procedures (CV)</u>	OHCA does not currently require Prior Authorization for the procedure codes listed.	Aetna will require prior authorization	The proposed changes attempt	APPROVED	
93304-Echo Transthoracic		for the procedure codes listed.	for the procedure codes listed.	to manage the utilization of specific codes and	
93303-TTE F-UP or LMTD			achieve overall cost savings for Aetna and its members.		
93351 -Stress TTE Complete					
93350 -Stress TTE Only					
Surgical Procedures					
22325 -Treat Spine Fracture					
21199 -Reconstr Lwr Jaw w/Advance					

SoonerSelect Medical Requests to Change Service Provisions				
PROCEDURE CODE(S) IMPACTED	OHCA'S CURRENT CLAIMS PROCESSING PROTOCOL	PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTCOL	ANTICIPATED IMPACT	OHCA DECISION
<u>Durable Medical</u> <u>Equipment (DME)</u>				
E0935 -Cont PSV Mot Exer Devc Knee Only				
E0730 -Tens Device 4/GT Leads Mx Nerve Stim				
Nerve Injections				
61640 -Injection Treatment of Nerve				

APA WF # 25-02 A&B *AD***vantage Waiver Policy Revisions** – The OHCA is seeking to revise the *AD*vantage Waiver policy to align with the 1915(c) Home and Community Based waiver amendment effective, October 1, 2023. Key revisions lower the minimum age from 21 to 19 for program eligibility, modify procedural requirements for obtaining member or representative signatures for home-delivered meals, reformat for clarity, and remove outdated language.

Budget Impact: Budget Neutral

APA WF # 25-05 Nursing Facility Durable Medical Equipment (DME) Revision — The proposed changes are to align administrative rules with the approved Oklahoma Medicaid State Plan, which states that the cost of DME is included in the nursing facility per diem rate and is not permitted to be billed separately.

Budget impact: Budget Neutral

APA WF # 25-03 SoonerSelect Policy Revisions – The Oklahoma Health Care Authority is proposing an emergency rule revision to align with the State's SoonerSelect 1915(b) waiver amendment. These proposed changes clarify that members receiving only family planning services through SoonerPlan are excluded from enrollment in the SoonerSelect program. Additionally, the choice period for SoonerSelect enrollees will be changed from 60 days to 30 days. The choice period is the timeframe during which a SoonerSelect enrollee may select a plan. If a selection is not made during this timeframe, the enrollee will be automatically assigned to one of the contracted entities.

Budget impact: Budget Neutral

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

317:30-5-760. ADvantage program

The ADvantage Programprogram is a Medicaid Home and Community Based Services (HCBS) Waiverwaiver used to finance noninstitutional long-term care services through Oklahoma's Medicaid program for elderly and disabled individuals: the elderly, sixty-five (65) years of age and older; and a targeted group of adults with physical disabilities, nineteen (19) to sixty-four (64) years of age who do not have an intellectual disability or a cognitive impairment related to a developmental disability per Oklahoma Administrative Code (OAC) 317:35-9. To receive ADvantage Program services, individuals must meet the nursing facility (NF) level of care (LOC) criteria, be age 65 years or older, or age 21 or older if physically disabled and not developmentally disabled, or if developmentally disabled and between the ages of 21 and 65, not have an intellectual disability or a cognitive impairment related to the developmental disability. ADvantage Program members must be Medicaid eligible and meet eligibility requirements per OAC 317:35-17. The number of members of individuals who may receive ADvantage services is limited.

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 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 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 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), (CDPASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASSCDPASS service delivery model, "Independent Living Philosophy," and demonstrate competency in 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 fifteen (15) minute unit of service using the rate associated with the location of residence of the member served.
 - (i) 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 twenty-five (25) persons per square mile.
 - (ii) Case management services are billed using a very rural/outside providers' 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 twenty-five (25) persons per square mile. Exceptions are services to members who reside in Oklahoma Human Services (OKDHS) Community Living, Aging and Protective Services identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.
 - (iii) The latest United States Census, Oklahoma counties population data is the source for determination of whether a member resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile or resides in a county with a population density greater than 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 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 fifteen (15) minute unit of service. Within any one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of 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 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 to the ADH care service and are covered by the ADH care basic reimbursement rate.
- (B) ADH care is a fifteen (15) minute unit of service. No more than eight (8) hours, [thirty-two (32) units] 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 National Academies of Sciences, Engineering, and Medicine, 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 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 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 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) OKDHS Home and Community-Based Services (HCBS) waiver settings have qualities defined in Home and Community-Based Services: Waiver Requirements, 42 Code of Federal Regulations, Section (§) 441.301 (c)(4) based on the individual's needs, 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) Social interactions.
- (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 HCBS settings per 42 C.F.R. § 441.301(c)(5)(v) include, ADH centers:
 - (i) In a publicly- or privately-owned facility providing inpatient treatment;
 - (ii) On the grounds of or adjacent to a public institution; and
 - (iii) With the effect of isolating individuals from the broader community of individuals not receiving ADvantage program or another Medicaid HCBS;
- (H) When the ADH is presumed not HCBS, according to 42 C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, the Oklahoma Health Care Authority (OHCA), and the 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 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 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 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 Oklahoma Medicaid State Plan are also included. This service excludes any equipment or supply items not of direct medical or remedial benefit to the waiver member 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 thirty percent (30%). 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 fifteen (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 state's Nurse 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 and in good standing in the state in which services are provided. 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 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 and the skilled nurse in accordance with review schedule determined between the case manager and the skilled nurse 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 personcentered 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 Board of Nursing in the state in which services are provided.
- (ii) In addition to assessment/evaluation, the ADvantage program case manager may recommend authorization of nursing services to:
 - (I) Prepare a one (1) week supply of insulin syringes for a person who is blind and has diabetes 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 a member with diabetes or 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 nurse's license, including private duty nursing. Nursing services are billed per fifteen (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, but 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 are listed in the person-centered service plan, within the state's Nurse Practice Act scope, and are ordered by a licensed physician, osteopathic

physician, physician assistant, or advanced practice nurse, and are provided by a RN, LPN, or LVN under the supervision of a RN, licensed to practice and in good standing in the state where services are provided. 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 fifteen (15) minute unit 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) mealup to two (2) meals 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 (1/3) of the dietary reference intakes as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering and Medicine. 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. Providers will redeliver missing meals as reported by the member unless the provider has a reliable mechanism for showing meals were delivered including, but not limited to, a signature of the member or the member's representative; a delivery driver's attestation that delivery occurred; a tracking statement of a common carrier, or delivery invoice of a common carrier. Signatures are not required to verify delivery. Electronic systems for verifying delivery are permitted.

(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 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 fifteen (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 thirty (30) calendar days. Any treatment required after the thirty (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 licensed physical therapist's supervision. 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 may be 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 an ADH service setting 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 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 (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 thirty (30) calendar days prior to the initial hospice authorization 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 sixty (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 personcentered 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 twelve (12) month period is limited to an amount equivalent to eighty-five percent (85%) 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 fifteen (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) 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 service criteria in (i) through (vi). The member:
 - (i) 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) Lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
 - (iii) Demonstrates the capability to comprehend the purpose of and activate the PERS;
 - (iv) 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) 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) Will likely avoid premature or unnecessary institutionalization as a result of PERS.
- (B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the ADvantage approved service plan.

(16) CD-PASS.CDPASS.

(A) <u>CD-PASSCDPASS</u> are personal services assistance (PSA) and advanced personal services assistance (APSA) that 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. <u>CD-PASSCDPASS</u> 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) Ensures the PSA or APSA has received sufficient instruction and training. If needed, the member/employer will work with the consumer-directed agent/case manager (CDA) to obtain training assistance from ADvantage skilled nurses. 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 assists a member with a stable, chronic condition with ADLs, 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 may order home health services, as appropriate. 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-PASSCDPASS 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 to 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 fifteen (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 personcentered service plan.
- (F) The APSA service is billed per fifteen (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) Institution transition services.

- (A) Institution transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage waiver services in his or her home and community.
- (B) Transitional case management services are services per 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, 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 to transition from institution to home by updating the person-centered service plan, including necessary institution 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 CAP to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.
 - (i) Institution transition case management services are prior authorized and billed per fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(D).
 - (ii) A unique modifier code is used to distinguish institution transitional case management services from regular case management services.
- (C) Institution 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) Institution transition services are provided to the member within 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 institution transition services but fails to enter the waiver, any institution transition services provided are not reimbursable.

(18) Assisted living services (ALS).

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes 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 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 ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC 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 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 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 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, 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 [Title 63 of the Oklahoma Statutes (O.S.), Section (§) 1-1902.17] 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 in I through IV 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 behaviors or actions that repeatedly and substantially interfere 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's 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's attempts to obtain appropriate member care.
- (IV) The member fails to pay room and board charges or OKDHS determined vendor payment obligation.
- (xi) Termination of residence ensues when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, if 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. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The 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 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, 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, or 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 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 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 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 (1) lavatory, one (1) toilet, and one (1) 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 an acceptable cooking appliance.
- (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 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 Nondiscrimination on the Basis of Disability By Public Accommodations and in in Commercial Facilities, 28 Code of Federal Regulations, 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 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 in a clean, safe, and sanitary manner, ensuring that they are 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 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 meal preparation and delivery.
- (X) The ALC must provide a twenty-four (24) hour response to personal emergencies 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, twenty-four (24) hours a day, and seven (7) days a week, to meet resident's needs and to carry out all 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 ADvantage program members' needs 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 state's 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 63 O.S. § 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 ALC's complaint procedures and the name, address, and 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's are those defined by OSDH, per OAC 310:663-19-1 and listed onin the AAProvider Question Critical Incident Reporting form. Category.
- (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 AAProvider Question Critical Incident Reporting form. Category. 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 five (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 ten (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 43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.
- (V) The preliminary incident report must at 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 minimum, include preliminary information, the extent of the injury or damage, if any, and preliminary investigation findings. The final report, at minimum, includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions, 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 that all health-related services required by the member as identified through assessment and documented on the personcentered 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) ALCs 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 ALS 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, instrumental activities of daily living (IADLs), and health care needs. The rate level is based on the 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 ninety (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 ninety (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 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) Available housing alternatives.
 - (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.

(19) Remote Support (RS) services.

- (A) **Purpose and scope.** RS services are intended to promote a member's independence and self-direction. RS services are provided in the member's home to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's person-centered service plan and coordination of these services are made through the case manager.
 - (i) RS services are:
 - (I) Based on the member's needs as documented and supported by the member's person-centered service plan and person-centered assessments;
 - (II) Only authorized when submitted on the member's person-centered service plan with the consent of the member, involved household members, and guardian, as applicable;
 - (III) The least restrictive option and the member's preferred method to meet an assessed need; and
 - (IV) Provided when the member and the member's Interdisciplinary Team (IDT) agree to the provision of RS services.
 - (ii) RS services are not a system of surveillance or for provider convenience.
- (B) **Service description**. RS services monitor a member by allowing for live, two-way communication between the member and monitoring staff using one (1) or more of the following systems:
 - (i) Live video feed:
 - (ii) Live audio feed;
 - (iii) Motion-sensor monitoring;

- (iv) Radio frequency identification;
- (v) Web-based monitoring; or
- (vi) Global positioning system (GPS) monitoring devices.
- (C) General provider requirements. RS service providers must have a valid OHCA SoonerCare (Medicaid) provider agreement to provide provider-based RS services to ADvantage HCBS waiver members and be certified by the AA. Requests for applications to provide RS services are made to AA.
- (D) **Risk assessment.** Teams will complete a risk assessment to ensure remote supports can help meet the member's needs in a way that protects the right to privacy, dignity, respect, and freedom from coercion. The risk assessment is reviewed, and any issues are addressed prior to the implementation of remote supports general provider requirements.
 - (i) Remote support providers ensure the member's health and safety by contacting a member's informal support or activating the member's back-up plan when a health or safety issue becomes evident during monitoring.
 - (ii) The risk assessment and service plan require the team to develop a specific backup plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided. The RS back-up plan includes how assistance is provided to the member when equipment or technology fails.
- (E) **RS guidelines.** Devices or monitors are placed at locations based on the member's individual needs as documented on the member's person-centered service plan and approved by the member and involved family members and guardian, as applicable.
 - (i) The use of camera or video equipment in the member's bedroom, bathroom, or other private area is prohibited.
 - (ii) When RS involves the use of audio or video equipment that permits RS staff to view activities or listen to conversations in the residence, the member who receives the service and each person who lives with the member is fully informed of what RS entails. The member's case manager documents consent in the member's personcentered service plan.
 - (iii) Waiver members have the ability to turn off the remote monitoring device or equipment if they choose to do so. The RS provider educates the member regarding how to turn RS devices off and on at the start of services and as desired thereafter.

(F) Emergency response staff.

- (i) Emergency response staff are employed by a certified ADvantage Provider with a valid OHCA SoonerCare (Medicaid) contract to provide HCBS to OKDHS HCBS waiver members.
- (ii) Informal emergency response persons are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member and the member's IDT.
- (G) **Service limitations.** RS services are limited to twenty-four (24) hours per day. RS services are not provided simultaneously with any other in-home direct care services. However, services may be provided through a combination of remote and in-home services dependent on the member's needs.
- (H) **RS service discontinuation**. The member and the member's IDT determine when it is appropriate to discontinue RS services. When RS services are terminated,

the RS provider coordinates service termination with the member's case manager to ensure a safe transition.

(20) Assistive Technology (AT) services.

- (A) AT services include devices, controls, and appliances, specified in the member's person-centered service plan, which enable members to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.
- (B) Devices may include communication technology, such as smart phones and tablets, that allow members to communicate with their providers using video chat to ensure ongoing maintenance of health and welfare.
- (C) Only devices that are not covered under the SoonerCare (Medicaid) or Specialized Medical Equipment services are included in this service definition.
- (D) Service codes and rates vary based on the nature of the AT device;
- (E) AT services may include:
 - (i) Assessment for the need of AT or auxiliary aids;
 - (ii) Training the member or provider regarding use and maintenance of equipment or auxiliary aids; and
 - (iii) Repair of adaptive devices; and
 - (iv) Equipment provided may include:
 - (I) Video communication technology that allows members to communicate with providers through video communication. Video communication allows providers to assess and evaluate their members' health and welfare or other needs by enabling visualization of members and their environments. Examples include smart phones, tablets, audiovisual or virtual assistant technology, or sensors; and (II) The cost of internet services may be augmented through the Emergency Broadband Benefit which is available to waiver members.

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

SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 1. SERVICES

- 317:35-9-1. Overview of long-term medical care services; relationship to <u>Qualified Medicare Beneficiary (QMB)</u>, <u>Specified Low-Income Medicare Beneficiary (SLMB)</u>, and other Medicaid services eligibility, and spenddown calculation
- (a) Long Term Medical Care Services. Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for the mentally retarded (refer to this subchapter), persons age 65 years or older in mental health hospitals (refer to this subchapter), Home and Community Based Waiver Services for the Intellectually Disabled (refer to this subchapter), and Home and Community Based Waiver Services for frail elderly and a targeted group of adults with physical disabilities age 21 and over who have not been determined to have a developmental disability, an intellectual disability or a related condition (refer to OAC 317:35-17). Personal Care provides services in the own home for categorically needy individuals (refer to OAC 317:35-15). Any time an individual is certified as eligible for Medicaid coverage of long-term care, the individual is also eligible for other Medicaid services. Another application or additional spenddown computation is not required. Spenddown is applied to the first long term care claim filed. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required. Any spenddown computed for long-term care is not applicable to QMB or SLMB coverage. Longterm medical care for the categorically needy includes:
 - (1) Care in a nursing facility, per Oklahoma Administrative Code (OAC) 317:35-19;
 - (2) Public and private intermediate care facility for individuals with intellectual disabilities, per OAC 317:35-9;
 - (3) Persons age sixty-five (65) years or older in mental health hospitals, per OAC 317:35-9; (4) Home and Community Based Waiver Services for the Intellectually Disabled, per OAC
 - 317:35-9;
 - (5) Home and Community Based Waiver Services for the ADvantage program, per OAC 317:35-17; and
 - (6) State Plan Personal Care provides services, per OAC 317:35-15.
- (b) Any time an individual is certified as eligible for Medicaid coverage of long-term care SoonerCare coverage, the individual is also eligible for other Medicaid SoonerCare services. Another application or additional spenddown computation is not required. Spenddown is applied to the first long-term care claim filed. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be is made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB)QMB or Specified Low-Income Medicare Beneficiary (SLMB)SLMB are met. Another application for QMB or SLMB benefits is not required. Any spenddown computed for long-term care is not applicable to QMB

or SLMB coverage.

(b)(c) Medicaid recovery. The State of Oklahoma operates a Medicaid Recovery program to recover <u>cost</u> for services identified in OAC 317:35-9-15. Recovery can be accomplished in two ways: liens against real property or claims made against estates.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-4. Application for ADvantage services

- (a) Application procedures for ADvantage services. If waiver slots are available, the application process initiates when an online application is completed for ADvantage services. A written financial application is not required for an individual who has an active Medicaid case. A financial application for ADvantage services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian, or someone else acting on the applicant's behalf.
 - (1) All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.
 - (2) When Medicaid application is being made, an assessment of resources must be completed. For applicants of the ADvantage waiver, those resources owned by the couple the month the application was made determines the spousal share of resources.
 - (3) When an application is received from an individual residing in a nursing facility, the applicant is referred to the Oklahoma Health Care Authority (OHCA)—Living Choice program as the appropriate entity to assist individuals from nursing facility care.
 - (A) If OHCA-Living Choice determines the applicant is ineligible for services due to the inability to assure health and welfare in a community setting, the individual is also ineligible for ADvantage waiver services.
 - (B) If OHCA-Living Choice determines the applicant does not meet Living Choice eligibility criteria for reasons unrelated to health and welfare, the individual is eligible for the ADvantage waiver if medically and financially approved.

(b) Date of application.

- (1) The date of application is:
 - (A) the date the applicant or someone acting in his/her behalf signs the application in the county office; or
 - (B) the date the application is stamped into the county office when the application is initiated outside the county office; or
 - (C) the date when the request for Medicaid is made orally and the financial application form is signed later. The date of the oral request is entered in "red" above the date the form is signed.
- (2) An exception is when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contracted provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for Medicaid eligibility determination. The application date is the date the applicant signed the application form for the provider.

(c) ADvantage waiting list procedures capacity. ADvantage Program "available capacity" is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. Upon notification from the AA that 90% of the available capacity has been exceeded, OKDHS Community Living, Aging and Protective Services notifies OKDHS county offices and contract agencies approved to complete the UCAT that, until further notice, requests for ADvantage services are not to be processed as applications but referred to AA to be placed on a waiting list of requests for ADvantage services. As available capacity permits, but remaining in compliance with waiver limits of maximum capacity, and until an increase in ADvantage available capacity occurs, the AA selects in chronological order (first on, first off) requests for ADvantage from the waiting list to forward to the appropriate OKDHS county office for processing the application. When the waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended. Waitlist procedures are implemented when the maximum number authorized by the waiver to be served in the waiver year is met.



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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE

317:30-5-133.2. Ancillary services

- (a) Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:
 - (1) Services requiring prior authorization:
 - (A) External breast prosthesis and support accessories.
 - (B) Ventilators and supplies.
 - (C) Total Parenteral Nutrition (TPN), and supplies.
 - (D) Custom seating for wheelchairs.
 - (2) Services not requiring prior authorization:
 - (A) Permanent indwelling or male external catheters and catheter accessories.
 - (B) Colostomy and urostomy supplies.
 - (C) Tracheostomy supplies.
 - (D) Catheters and catheter accessories.
 - (E) Oxygen and oxygen concentrators.
 - (i) PRN Oxygen. Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.
 - (ii) Billing for Medicare eligible members. Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.
- (b) Items not considered ancillary, but considered routine and covered as part of the routine rate include but are not limited to:
 - (1) Diapers.
 - (2) Underpads.
 - (3) Medicine cups.
 - (4) Eating utensils.
 - (5) Personal comfort items.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 55. MANAGED CARE

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

317:55-3-1. Mandatory, voluntary, and excluded populations

- (a) Mandatory populations. The following SoonerCare Eligibles will be mandatorily enrolled with a CE and DBM under the SoonerSelect Dental and Medical program:
 - (1) Expansion adults;
 - (2) Parents and caretaker relatives;
 - (3) Pregnant women;
 - (4) Deemed newborns:
 - (5) Former foster children;
 - (6) Juvenile justice involved children;
 - (7) Foster care children;
 - (8) Children receiving adoption assistance; and
 - (9) Children.
- (b) Voluntary populations. SoonerCare Eligible individuals may voluntarily choose to enroll in the SoonerSelect Dental and Medical program through an opt-in process if they are American Indians and/or Alaskan Natives. AI/AN populations will have the option to:
 - (1) Voluntarily enroll in the DBM and/or CE through an opt-in process;
 - (2) Enroll in a DBM and/or CE at each open enrollment period, regardless of initial selection or past disenrollment from the DBM and/or CE;
 - (3) When enrolled, AI/AN populations may:
 - (A) Receive services from an IHCP;
 - (B) Choose the IHCP as the Enrollee's provider, if the provider has the capacity to provide such services;
 - (C) Obtain services covered under the Contract from out-of-network IHCPs when the Enrollee is otherwise Eligible to receive the IHCP's services;
 - (D) Self-refer for services provided by IHCPs to AI/AN Enrollees;
 - (E) Obtain services covered under the Contract from out-of-network IHCPs when the AI/AN Enrollee is otherwise Eligible to receive the IHCP's services;
 - (F) Disenroll from any DBM and/or CE at any time without cause.
- (c) Excluded populations. The following individuals are excluded from enrollment in the SoonerSelect program:
 - (1) Dual-eligible individuals;
 - (2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);

 - (3) Persons with a nursing facility or ICF-IID level of care, except for Enrollees with a pending level of care determination;
 - (4) Individuals during a period of presumptive eligibility;
 - (5) Individuals infected with tuberculosis Eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
 - (6) Individuals determined Eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;

- (7) Individuals enrolled in a § 1915(c) Waiver;
- (8) Undocumented persons Eligible for emergency services only in accordance with 42 C.F.R. § 435.139;
- (9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Medicaid State Plan;
- (10) Coverage of Pregnancy-Related Services under Title XXI for the benefit of unborn children ('Soon- to-be-Sooners'), as allowed by 42 C.F.R. § 457.10; and
- (11) Individuals determined Eligible for Medicaid on the basis of age, blindness, or disability.
- (12) Individuals enrolled in the SoonerPlan family planning program.
- (d) **Additional eligibility criteria.** For additional eligibility criteria, refer to Chapter 35 Medical Assistance for Adults and Children Eligibility Manual, Subchapter 5 Eligibility and Countable Income.

317:55-3-2. Enrollment and disenrollment process

- (a) Enrollment process. The OHCA beneficiary support system will provide choice counseling to all potential Enrollees at the time of initial enrollment, during the annual open enrollment period and for Enrollees who disenroll from a CE or DBM for good cause as described in the Contract and in this Section. The OHCA, or its designee, will provide information about individual CE or DBM benefit structures, services, and network providers, as well as information about other Medicaid programs as requested by the Eligible to assist the Eligible in making an informed selection.
 - (1) **Selection/auto assignment.** During the application process, at OHCA's discretion, an Applicant may have up to sixty (60)thirty (30) days to select a contracted CE and DBM of their choice. Applicants who are Eligible to choose a CE and DBM and fail to make an election on the SoonerCare application, within the allotted timeframe, will be assigned to the CE and DBM that is due next to receive an auto assignment.

(2) Exemptions to auto-assignments

- (A) The OHCA will not make auto-assignments to the CE if:
 - (i) The CE's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;
 - (ii) The CE has been excluded from receiving new enrollment due to the application of non-compliance remedies; or
 - (iii) The CE has failed to meet readiness review requirements.
- (B) The OHCA will not make auto-assignments to the DMB if:
 - (i) The DBM's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;
 - (ii) The DBM has been excluded from receiving new enrollment due to the imposition of administrative remedies; or
 - (iii) The DBM has failed to meet readiness review requirements.

(3) Enrollment effective date

(A) Eligibles, with the exception of deemed newborns, who select or are assigned to a CE and/or DBM from the first day of the month through the fifteenth day of the month shall be enrolled effective on the first day of the following month.

- (B) Eligibles who select or are assigned to a CE and/or DBM on the sixteenth (16th) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.
- (C) Prior to these enrollment dates, most Eligibles will be covered by a fee-for-service payment structure administered by OHCA.
- (D) Deemed newborns eligible for the CE and/or DBM shall be enrolled effective as of the date of birth, if the newborn's mother also is enrolled in the SoonerSelect program.
- (E) Notwithstanding the foregoing, the effective date of enrollment with the CE or DBM shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.
- (4) Enrollment lock-in period. An Enrollee may, within the first ninety (90) days of initial enrollment, request to change enrollment without cause from the CE and/or DBM, or during the ninety (90) days following the date OHCA sends the Enrollee notice of initial enrollment, whichever is later. Enrollees will also be permitted to change CEs and/or DBMs, without cause, at least once every twelve (12) months during the open enrollment period. After the disenrollment period from the CE or DBM has lapsed, the Enrollee will remain enrolled with the CE or DBM until the next annual open enrollment period, unless:
 - (A) The SoonerSelect Medical Enrollee:
 - (i) Is disenrolled due to loss of SoonerCare eligibility;
 - (ii) Becomes a foster child under custody of the state;
 - (iii) Becomes juvenile justice involved under the custody of the state;
 - (iv) Is a former foster care or child receiving adoption assistance and opts to enroll in the SoonerSelect Children's Specialty program;
 - (v) Demonstrates good cause under the following conditions:
 - (I) The Enrollee moves out of the service area;
 - (II) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;
 - (III) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;
 - (IV) The Enrollee needs related services to be performed at the same time; not all related services are available within the CE's network; and the Enrollee's primary care provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;
 - (V) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and
 - (VI) The Enrollee has been enrolled in error, as determined by the OHCA.

- (vi) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or
- (vii) The OHCA has imposed intermediate sanctions on the CE and allows Enrollees to disenroll without cause.
- (B) The SoonerSelect Dental Enrollee:
 - (i) Is disenrolled due to loss of SoonerCare eligibility;
 - (ii) Demonstrates good cause under the following conditions:
 - (I) The Enrollee moves out of the service area;
 - (II) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;
 - (III) The Enrollee needs related services to be performed at the same time; not all related services are available within the DBM's network; and the Enrollee's primary care dental provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;
 - (IV) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and
 - (V) The Enrollee has been enrolled in error, as determined by the OHCA.
 - (iii) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or (iv) The DBM is terminated.
- (5) **Annual and special enrollment periods.** Sixty (60) days prior to the start of the Enrollee's annual open enrollment period, the Enrollee shall be notified of the option to maintain enrollment with the current CE and/or DBM or to enroll with a different CE and/or DBM. OHCA, at its sole discretion, may schedule a special open enrollment period, under the following circumstances:
 - (A) In the event of the early termination of a CE or DBM under the process described in the Contract; or
 - (B) The loss of a major participating provider(s) places the CE or DBM at risk of failing to meet service accessibility standards and the CE or DBM does not have an acceptable plan for mitigating the loss or finding of non-compliance.
- (6) **Enrollment caps.** OHCA, at its sole discretion, may impose a cap on the CE or DBM's enrollment, in response to a request by the CE or DBM or as part of a corrective action in accordance to the respective Contract.
- (b) **Disenrollment**. The OHCA shall have sole authority to grant or deny a disenrollment request from the Enrollee, and/or CE or DBM.
 - (1) **CE or DBM-requested disenrollment**. Pursuant to 42 C.F.R. § 438.56(b)(2), the CE or DBM cannot request a disenrollment based on adverse change in the member's health status or utilization of medically necessary services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs, except when

their continued Enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees.

- (A) The CE may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:
 - (i) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;
 - (ii) The Enrollee has been enrolled in error, as determined by OHCA;
 - (iii) The Enrollee has exhibited disruptive behaviors to the extent the CE cannot effectively manage their care, and the CE has made all reasonable efforts to accommodate the Enrollee; or
 - (iv) The Enrollee has committed fraud, including but not limited to, loaning an identification (ID) card for use by another person.
- (B) The DBM may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:
 - (i) The Enrollee has been enrolled in error, as determined by OHCA;
 - (ii) The Enrollee has exhibited disruptive behaviors to the extent the DBM cannot effectively manage their care, and the DBM has made all reasonable efforts to accommodate the Enrollee; or
 - (iii) The Enrollee has committed fraud, including but not limited to, loaning an ID card for use by another person.
- (2) Enrollee-requested disenrollment. Enrollees shall seek redress through the CE's or DBM's grievance process before OHCA will make a determination on an Enrollee's request for disenrollment. The CE or DBM shall accept Enrollee requests for disenrollment orally or in writing. The CE or DBM shall complete a review of the request within ten (10) days of the Enrollee filing the grievance. If the Enrollee remains dissatisfied with the result of the grievance process, the CE or DBM shall refer the disenrollment request to OHCA. The Contractor shall send records gathered during the grievance process to OHCA to facilitate OHCA's decision-making process. Disenrollment requests will be adjudicated by OHCA and, if approved, will become effective on a date established by OHCA.
 - (A) The Enrollee may request disenrollment from the CE or DBM as allowed by 42 C.F.R. § 438.56(c).
 - (B) An Enrollee may request disenrollment from the CE or DBM at any time based on any cause listed at 42 C.F.R. § 438.56(d)(2).
 - (C) An Enrollee may request disenrollment at any time in accordance with (a)(4)(A)(v)(I)-(VI) and (B)(ii)(I)-(V) of this Section and the applicable Contract.
- (3) **Disenrollment by OHCA.** The CE or DBM shall report to OHCA, within five (5) business days of learning of any change in an Enrollee's status affecting the Enrollee's eligibility.
 - (A) The OHCA will initiate disenrollment of SoonerSelect Medical Enrollees under the following circumstances:
 - (i) Loss of eligibility for Medicaid;

- (ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Medical program;
- (iii) Enrollee becomes enrolled in Medicare;
- (iv) Death;
- (v) Enrollee becomes a foster child under the custody of the state;
- (vi) Enrollee becomes juvenile justice involved under the custody of the state;
- (vii) The Enrollee becomes an inmate of a public institution;
- (viii) The Enrollee commits fraud or provides fraudulent information; or
- (ix) Disenrollment is ordered by a hearing officer or court of law.
- (B) The OHCA will initiate disenrollment of SoonerSelect Dental Enrollees under the following circumstances:
 - (i) Loss of eligibility for Medicaid;
 - (ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;
 - (iii) Enrollee becomes enrolled in Medicare;
 - (iv) Death;
 - (v) The Enrollee becomes an inmate of a public institution;
 - (vi) The Enrollee commits fraud or provides fraudulent information; or
 - (vii) Disenrollment is ordered by a hearing officer or court of law.
- (4) **Disenrollment effective date**. Consistent with 42 C.F.R. § 438.56(e), except as provided for below, and unless OHCA determines that a delay would have an adverse effect on an Enrollee's health, it is OHCA's intent that a disenrollment shall be effective no later than the first day of the second following month.
 - (A) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the Enrollee's health care needs or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the CE fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the CE complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the Enrollee's SoonerSelect Medical program eligibility status changes:
 - (i) Loss of eligibility for Medicaid;
 - (ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect program;
 - (iii) Enrollee becomes a foster child under the custody of the state;
 - (iv) Enrollee becomes JJ Involved under the custody of the state;
 - (v) Enrollee becomes eligible for Medicare;
 - (vi) Death;

- (vii) Enrollee becomes an inmate of a public institution;
- (viii) Enrollee commits fraud or provides fraudulent information;
- (ix) Disenrollment is ordered by a hearing officer or court of law; or
- (x) Enrollee requiring long-term care.
 - (I) Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the CE when the level of care determination is finalized.
 - (II) For additional information regarding nursing facility and ICF-IID stays, refer to the Contract.
- (B) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the SoonerSelect Dental Enrollee's oral health care needs, or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the Contractor fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the Contractor complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the SoonerSelect Dental Enrollee's SoonerSelect Dental program eligibility status changes:
 - (i) Loss of eligibility for Medicaid;
 - (ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;
 - (iii) SoonerSelect Dental Enrollee becomes eligible for Medicare;
 - (iv) Death;
 - (v) SoonerSelect Dental Enrollee becomes an inmate of a public institution:
 - (vi) SoonerSelect Dental Enrollee commits Fraud or provides fraudulent information;
 - (vii) Disenrollment is ordered by a hearing officer or court of law; or
 - (viii) SoonerSelect Dental Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the Contractor when the level of care determination being done by the SoonerSelect or SoonerSelect Children's Specialty CEs is complete.
- (C) Notwithstanding the foregoing, the effective date of disenrollment from the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.
- (c) **Retroactive dual eligibility.** Dual eligibles are excluded from the SoonerSelect program. SoonerSelect Enrollees who become dual eligible individuals will be disenrolled as of their Medicare eligibility effective date.

- (1) In the event a SoonerSelect Enrollee becomes retroactively Medicare eligible, the CE or DBM shall recover claims payments made to providers during the months of retroactive Medicare eligibility.
- (2) The CE or DBM shall also notify the provider of the requirement to submit the claim to Medicare for reimbursement.
- (3) OHCA will recoup the capitation payments paid for months of retroactive Medicare eligibility.
- (d) **Re-enrollment following loss of eligibility.** Enrollees who lose and regain eligibility for SoonerSelect Medical or Dental program within a period of sixty (60) days or less will be re-enrolled automatically with their prior CE and/or DBM unless the CE and/or DBM is otherwise suspended or excluded from receiving new Enrollees. Re-enrolled Enrollees will have the right to change CE/DBM in accordance with this Section and the Contract.
- (e) Eligibles voluntarily opting out of SoonerSelect Children's Specialty Program. FFC and children receiving adoption assistance shall be enrolled in the SoonerSelect Children's Specialty Program. These Eligibles may opt-out of enrollment in the Children's Specialty Program; however, the legal guardian of the Eligible will be required to enroll the Eligible with a CE.
- (f) **Non-discrimination**. The CE or DBM may not refuse an assignment or seek to disenroll an Enrollee or otherwise discriminate against Eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, need for medical services, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. The Contractor also may not discriminate against an Enrollee on the basis of expectations that the Enrollee will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the Enrollee's health in enrollment, disenrollment, or re-enrollment. If the CE or DBM fails to comply with OAC 317:55-3-2, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.