Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

May 18th, 2017
1:00 PM – 3:30 PM

Charles Ed McFall Board Room

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

II. Action Item: Approval of Minutes of the March 9th, 2017: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Gloria Hudson, Director of General Accounting**

   A. 2018 Budget Update**, Carrie Evans, Chief Financial Officer/Tywanda Cox, Chief of Federal and State Policy**

VI. SoonerCare Operations Update: **Kevin Rupe, Member Services Director**

   A. Action item: Provider Program Integrity Update: **Josh Richards, Provider Audits Director**

VII. Legislative Update: **Austin Marshall, Government Relations Director**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Demetria Bennett, Policy Development Coordinator**

   A. 17-01 Policy Revision to Comply with Fairness in Medicaid Supplemental Needs Trusts Act
   B. 17-02 Self-Employment Language in Insure Oklahoma
   C. 17-04 A&B MFP PRTF Wraparound Services Demonstration

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

X. Discussion Items Only: **Ivoria Holt, Waiver Development & Reporting Director**

   A. 1115 renewal

XI. New Business: **Chairman, Steven Crawford, M.D**

XII. Future Meeting:
July 20th, 2017

XIII. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the March 9, 2017 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

Chairman Steven Crawford called the meeting to order at 1:00 PM.

***Delegates present were*:** Ms. Renee Banks, Ms. Teresa Bierig, Ms. Debra Billingsley, Dr. Joe Catalano, Dr. Steve Crawford, Dr. Arlen Foulks, Mr. Mark Jones, Ms. Annette Mays, Mr. Victor Clay, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Mr. Rick Snyder, Mr. Jeff Tallent, and Dr. Gail Poyner

Alternates present were: Ms. Lois Baer, Ms. Joni Bruce, Mr. Traylor Rains-Sims, and providing a quorum.

***Delegates absent without an alternate were*:** Dr. David Cavallaro, Ms. Terri Fritz, Ms. Melissa Gastorf, Dr. Steve Goforth, Dr. Ashley Orynich, Mr. James Patterson, Dr. J. Daniel Post, and Dr. Edd Rhoades, Mr. David Rising, Dr. Kanwal Obhrai, and Dr. Paul Wright

II. Approval of January 19, 2017 Minutes

Medical Advisory Committee

Chairman Crawford did a call to vote to approve the meeting minutes for January 19th, 2017. It was motioned by Ms. Toni Pratt-Reid and Dr. Joe Catalano seconded the motion. All members voted to approve the minutes.

III. Public Comments (2 minute limit)

Ms. Connie Crew spoke on behalf friend, who is a member but could not attend the MAC meeting. Ms. Crew stated that the drug law is creating a problem for those members that are in pain. The member cannot afford pain medicines that are not currently covered by Medicaid.

IV. MAC Member Comments

Dr. Crawford commented on the supplemental payment issue associated with the current ABD contract; however because bids have been submitted, OHCA cannot talk about it at this time. Dr. Crawford expressed his concerns regarding the consequence of what happens with SHOPP, Trauma funds, GME, etc. the consequences could be significant for the state. The Hospital Association has similar concerns. Mr. Snyder stated they are investigating what possibilities there may be in the future.

V. Financial Update:

Gloria Hudson, Director of General Accounting

Ms. Hudson reported on the state's Fiscal Year 2017 financial transactions through the month of December. She reported that the state budget variance is a positive $4.8 million dollars. On the expenditure side, OHCA is under budget with the Medicaid Program by 1.6% for $7.3 million state

dollars and in administration by 6.5% for $1.7 million state dollars. On the revenue side, we were over budget on Drug Rebates and Collections by 1.5% for negative $0.9 million state dollars and under budget in Settlements and Overpayments by 30.9% for negative $2.8 million state dollars and in Tobacco Tax Collections and Fees by 2% for negative $0.5 million state dollars. On Feb 21, Preston Doerflinger announced a state rev failure for 2017. To rectify shortfall and maintain the legally mandated balanced budget, state agency appropriations are being reduced by 0.7% for loss of 4.65 million state dollars. At this time OHCA is operating with a positive 4.8 million dollar variance, therefore barring any addition revenue failures, OHCA management believes the agency can finish this fiscal year without making additional cuts. With preliminary data in through the month of December it looks like our agency will continue to remain slightly under budget.

VI. SoonerCare Operations Update:

Nancy Nesser, PharmD, Pharmacy Director

Ms. Nesser presented the SoonerCare Operations Update to the committee. She presented information based on data for December of 2016. Patient Centered Medical Home enrollment is at 549,184 which is a decrease from the previous month by 12. Sooner Care Traditional has a current enrollment of 231,228 which is 1,403 less than the previous month. SoonerPlan is down by 710, giving a total of 34,058. Insure Oklahoma has a total enrollment of 20,127 of which 4,865 are in the Individual Plan and 15,262 are in the Employee Sponsored Plan which is an increase of 236 from the previous month. In total, SoonerCare enrollment is at 834,597 for December which is a decrease of 1,889. Total In-State providers are up by 502, giving a total of 33,370.

a. Pharmacy Program Overview:

Nancy Nesser, PharmD, Pharmacy Director

Ms. Nesser gave an overview on the Pharmacy Program, which included pharmacy program stats from SFY 2016, SoonerCare Pharmacy Program Background, Federal Medicaid Pharmacy Policy, Adult Pharmacy Benefits, Federal Drug Rebate Program, Net Cost Illustration, Branded Drugs, and Pharmacy Program Results. When asked if budget cuts could affect pharmacy, Ms. Nesser stated possibly. For more detailed information, see item 6A in the Final MAC agenda.

b. Hospice Benefit Update:

Allison Latham, Social Services Coordinator, Population Care Management

Ms. Latham presented on Hospice Benefits which included information regarding the difference between hospice and palliative care, hospice services for children, 2010 federal mandate, common questions, how the process begins, and hospice for adults. For more detailed information, see item 6B in the Final MAC Agenda.

c. Provider Enrollment Update:

Amy Bradt, Director of Provider Enrollment

Ms. Bradt presented on Provider Enrollment, which included what provider enrollment does, categorical risk levels, low risk provider screenings, moderate risk provider screenings, high risk providers, providers moved to high risk, and additional screenings. For more detailed information please see item 6C in the Final MAC Agenda.

Comments: Dr. Catalano asked if OHCA was an enforcement agency. Ms. Bradt stated that OHCA only screens prior to enrollment.

Mr. Jeff Tallent asked, of 100 providers, how many fall into the high and moderate categories. How accurate are OHCA's predictions? Ms. Bradt stated the predictions made by OHCA are pretty accurate. As of right now, OHCA is only completing screens on federally required groups, such as home health and DME.

Dr. Catalano asked if the committee could receive responses regarding these issues:

- Program Integrity audit category findings, including the highest level of fraud and provider types
- How many children are currently on hospice – Dr. Crawford followed up on the number of pediatric hospice cases. There have been 33 pediatric hospice cases in the previous year and as many as 6 at any one time and as low as 1.
- How many Hospice offices provide free services

VII. Legislative Update:

Emily Shipley, Director of Governmental Affairs

Ms. Shipley stated HB 1579, which will allow OHCA to set up data exchange with DPS, passed the House floor; it will head to the Senate for consideration. SB 773, the foster children care coordination model, passed both Senate committees and will be heard on the Senate floor in the coming weeks. SB 798, OHCA provider audit appeals, passed in Senate committee and is set to be heard on the Senate floor. SB 819, which would change the property liens process, passed both Senate committees and introduced in House on February 27, 2017. SB 828, which would create a new revolving fund, passed the Senate committee. All Bills are now being heard on both Senate and House floors. State Board of Equalization finalized numbers on money that the state has to appropriate and is working to determine next steps. May 26th will be the last day of session.

VIII. Proposed Rule Changes:

Demetria Bennett, Policy Development Coordinator

Ms. Bennett proposed seven rule changes. She noted that all seven rules were presented at the September 6, 2016 and November 1, 2016 Tribal Consultation meetings. All rules were posted on OHCA's public website for comment on December 16, 2016 through January 15, 2017. These rules will also be presented at the February Board Meeting.

16-03 Aggregate Cost Sharing — The proposed revisions update language to mirror Federal regulation for cost sharing. Per current policy, the aggregate cost sharing liabilities in a given calendar year may not exceed five percent of the *member's* gross annual income. Per Federal regulation, the aggregate limit on premiums and cost sharing incurred by *all members* in the Medicaid household should not exceed five percent of the *family's income* applied on a monthly basis.

Budget Impact: Budget neutral

Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Dr. Joe Catalano

16-16B Nursing Facility Supplemental Payment Program — The proposed policy revisions clarify eligibility requirements and care criteria for nursing facilities.

Budget Impact: Budget neutral

Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Ms. Toni Pratt-Reid

16-18 Telemedicine Revisions — The proposed revisions replace telemedicine with telehealth to allow the flexibility for use of telehealth technologies that could be used to deliver healthcare services to SoonerCare members. In addition, revisions also define telehealth and specific telehealth technologies.

Budget Impact: Budget neutral

Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Mr. Victor Clay

16-19 Additional Tax Equity and Fiscal Responsibility Act Developmental Evaluation Options — The proposed revisions allow additional providers to evaluate Tax Equity and Fiscal Responsibility Act applicants under the age of three for the measurement of developmental milestones to determine Intermediate Care Facilities for Individuals with Intellectual Disabilities institutional level of care. Current rules only allow for an evaluation by providers within the SoonerStart Early Intervention Program. This policy revision allows for flexibility when determining level of care as there are other appropriate providers and evaluation tools that can be utilized to evaluate developmental milestones. Please note that other criteria for severe dysfunctional deficiencies in at least two total domain areas remain in effect.

Budget Impact: Budget neutral

Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Dr. Arlen Foulks

16-24A Developmental Disabilities Services Revisions — The proposed revisions to the Developmental Disabilities policy includes minor language cleanup, which adds the acronym for agency companion services and replaces the Oklahoma Department of Human Services acronym from "OKDHS" to "DHS." In addition, revisions change the name of the OKDHS Children and Family Services Division to DHS Child Welfare Services. Finally, revisions add the correct reference for agency companion services limits.
Budget Impact: Budget neutral
Rule Change was motioned to approve by Dr. Joe Catalano and seconded by Mr. Jeff Tallent

16-24B Developmental Disabilities Services Revisions — The proposed revisions to the Developmental Disabilities policy adds language to outline the standards for transportation providers and requirements for a Self-Directed Habilitation Training Specialist. Revisions specify that Home and Community-Based Waiver services require an annual eligibility review. Further language is added to define competitive integrated employment. In addition, the proposed revisions remove the treatment plan pre-approval requirements that exceed $1,000 by the Developmental Disabilities Services area medical director or designee for members of the Homeward Bound Waiver. Finally, requirements regarding that the provider agency Human Rights Committees review the member's protective intervention protocols are removed.
Budget Impact: Budget neutral
Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Ms. Annette Mays

16-25A ADvantage Waiver Revisions — The proposed revisions to the ADvantage waiver policy add language to comply with new Centers for Medicare & Medicaid Services (CMS) rules regarding Adult Day Health providers in Home and Community Based (HCB) settings.. Revisions clarify the required processes for case management monitoring and reporting activities for all waiver services. Revisions update commonly used terms and replace "plan of care" with the term "person-centered service plan." Additional revisions clarify that the Consumer-Directed Personal Assistance Services and Supports (CD-PASS) option is available in every Oklahoma County. Further, wording is added that is consistent with the Physical Therapy Act. The proposed revisions clarify maximum billing units per day for skilled nursing services. Revisions also clarify that the minimum of eight units is equivalent to two hours and that the 28 maximum billing units is equivalent to seven hours. Revisions update services that are provided by the ADvantage waiver program and remove those services no longer available. Revisions clarify the provider contract processes and those providers that are required to have annual audits. In addition, Adult Day Health and Assisted Living are added to the list of providers and are included in the periodic programmatic audit. Further revisions remove reference for the CD-PASS and Advanced Person Services Assistants to be documented through the Electronic Visit Verification System solely for reimbursement. Finally, language

regarding speech and language therapy services is revoked as it is no longer offered in the ADvantage waiver.

Budget Impact: Budget neutral

Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Ms. Annette Mays

16-25B ADvantage Waiver Revisions — The proposed revisions to the ADvantage waiver policy adds language regarding the personal care services process provided by the personal care provider agency nurse. Additional language outlines individuals who are not qualified to provide services as an Individual Personal Care Assistant. Language is added to clarify technical services that are provided by the State Plan Personal Care services program. Additional guidance is provided on the Oklahoma Department of Human Services (DHS) forms that are to be used in the eligibility process for personal care service authorization. Further revisions provide clarification on payment for personal care services if the client lives in the personal care assistant's home without DHS approval. Proposed revisions provide clarification on the timeframe in which nurses are to complete the Service Authorization Model visit and outline the steps to be taken if it is determined that there have been no changes in health or service needs. Language regarding the current practices and form numbers of Nursing Home Level of Care assessments has been updated. Additional revisions reflect changes due to the Interactive Voice Response Authentication (IVRA) system to the Electronic Visit Verification (EVV) system. Processes for documentation through the EVV system have been defined. Language is added that would identify what members would not be able to receive ADvantage waiver services due to illegal drug activity in the home. Additional updates are made to clarify mental impairment language. Further, references made to the Supplemental Process for Expedited Eligibility Determination are removed as this process is no longer part of the ADvantage waiver. In addition, services that are no longer provided by the ADvantage waiver have been removed.

Budget Impact: Budget neutral

Rule change was motioned to approve by Ms. Annette Mays and seconded by Mr. Jeff Tallent

16-28A Policy Revisions to Contracting Rules — The proposed revisions revoke administrative sanction policy as the language is obsolete and does not accord with current agency practices. Proposed revisions also revoke other agency rules which have been substantively revised to clarify what the agency may consider when deciding whether to terminate a contract with a particular enrolled provider. Additionally, proposed revisions add a new rule which explains what factors OHCA may take into consideration when deciding whether to approve an application for a new or renewing provider enrollment contract. Further revisions add a new rule which modifies and replaces the Emergency Rule that will expire on September 14, 2017. The new rule fulfills a Federal requirement for all state Medicaid agencies to institute fingerprint-based criminal background checks for certain "high categorical risk" providers who want to contract with the state. Proposed revisions also add a new rule which streamlines,

clarifies and provides examples of the kinds of conduct that may serve as a basis for a forcause termination of a provider contract.
Budget Impact: Budget neutral
Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Dr. Arlen Foulks

16-28B Policy Revisions to Appeals Rules — The proposed revisions remove references to administrative sanction rules, which are being revoked.
Budget Impact: Budget neutral
Rule change was motioned to approve by Mr. Rick Snyder and seconded by Mr. Jeff Tallent

16-29 General Policy Language Cleanup — The proposed revisions update references to the physical address of the Oklahoma Health Care Authority, and correct formatting errors and misspelled words. Revisions also include replacing the words "recipient" and "patient" with the word "member." In addition, the word "certified" will be added to nurse midwives. This change will allow policy language to reflect language utilized by the Oklahoma Nursing Board.
Budget Impact: Budget neutral
Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Ms. Annette Mays

16-30 Insure Oklahoma Policy Changes and Cleanup — The proposed revisions to the Insure Oklahoma policy include adding language to the definitions of "Full-time Employment" and "Full-time Employer." Definitions also clarify dependent and independent college student's enrollment requirements. Revisions remove references to annual and lifetime maximums to mirror current waiver authority. In addition, references to prosthetic devices, continuous positive airway pressure devices, and perinatal dental coverage are removed to mirror current SoonerCare coverage. Revisions also remove references to individuals under supervision and update the therapy limits for behavioral health services to mirror current SoonerCare coverage.
Budget Impact: Budget neutral
Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Ms. Annette Mays

16-31A Long Term Care Policy Revisions — The proposed Long Term Care policy revisions update requirements for the State Survey Agency when they are certifying facilities with deficiencies. Revisions also amend the change of ownership process for facilities. Both revisions are necessary to comply with recent changes to Federal and State regulation. Revisions clarify that nursing facilities will be afforded a hearing pursuant to Federal regulation. For nursing homes that handle trust accounts, the Department of Human Services allows facilities to use electronic ledgers and bank statements as source documents for inspections, accounting, and tracking purposes. Proposed revisions update rules to align with this practice. Further revisions amend rules governing quality of care fund requirements to accurately reflect how these funds are calculated and assessed as authorized by Oklahoma Statutes. Proposed revisions also strike partial Federal regulation language that is used in rules. Other revisions

update the payment methodology for private nursing facilities to mirror language found in the State Plan, and adds influenza and pneumococcal vaccines as a covered routine service since they are not separately reimbursable. Additionally, revisions throughout amend terminology to correctly identify individuals residing in long term care facilities as those with intellectual disabilities and replaces the term "patient" with "member" as appropriate. Other general cleanup of terms include: replacing "agreement" with the term "contract," updating form names, revising the name of divisions, and striking references to policy that has been revoked. In addition, revisions for trust funds revoke language that implies unclaimed funds escheats to the State. Further changes revoke rules outlining the necessary requirements for members to obtain a private room. Nursing facilities receive a set reimbursement for room and board regardless of the privacy level so prescriptive rules are not required.
Budget Impact: Budget neutral
Rule change was motioned to approve by Ms. Annette Mays and seconded by Dr. Joe Catalano

16-31B Long Term Care Policy Revisions — The proposed Long Term Care policy revisions amend terminology to correctly identify individuals residing in Long Term Care facilities as those with intellectual disabilities and replaces the term "patient" with "member" as appropriate.
Budget Impact: Budget neutral
Rule change was motioned to approve by Mr. Traylor Rains-Sims and seconded by Dr. Arlen Foulks

16-32 Provider Contracting Updates and Language Cleanup — The proposed revisions ensure that policy mirrors the Oklahoma Health Care Authority (OHCA) contracting requirements for Optometrists, Renal Dialysis Facilities, and Podiatrists. Birthing Center policy is also amended to clarify that a contract with the OHCA is required to be reimbursed for services. The proposed change will align Birthing Centers policy with all other provider types. Lastly, proposed revisions update Hospital policy to mirror OHCA contracting requirements, update outdated statutes for reporting abuse, and amend abuse reporting requirements.
Budget Impact: Budget neutral
Rule change was motioned to approve by Dr. Arlen Foulks and seconded by Mr. Jeff Tallent

16-33 Therapeutic Foster Care Policy Revisions — The proposed Therapeutic Foster Care revisions remove minimum time requirements for behavioral health assessment services to allow providers more flexibility in completing biopsychosocial assessments. Revisions also add frequency limitations to clarify limits on how often an assessment can be completed within a single agency. In addition, revisions specify if an assessment is performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional that is responsible for the member's care. This change will clarify oversight requirements for licensure candidates and ensure quality of care. Rules are also revised to specify clinical documentation requirements when changes need to be made to the service plan prior to the scheduled three month review or update. Finally, revisions update numerical references and add taglines to align

with current Administrative Procedures Act guidelines.
Budget Impact: Budget neutral
Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Mr. Traylor Rains-Sims

16-34 Diagnostic Cast and Oral/Facial Images — The proposed revisions add language that allows dental providers to submit the diagnostic cast or photographic images as evidence of medical necessity for dental services. The procedure is a necessary part of many dental practices, including orthodontics, and the change allows providers to bill for a necessary service. In addition, revisions add the term "certified" to nurse midwife to mirror terminology used by the Oklahoma Nursing Board.
Budget Impact: Agency staff has determined that the proposed rule may result in a cost savings of $14,395 total dollars; State share $4,375; Federal share $10,560.
Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Mr. Traylor Rains-Sims

16-35 Outpatient Behavioral Health Policy Revisions — The proposed policy revisions remove outdated references to Axis diagnosis to align with changes to the Diagnostic and Statistical Manual of Mental Disorders. In addition, revisions clarify clinical outpatient behavioral health agency provider documentation requirements for when changes need to be made to the service plan prior to the scheduled six month review or update. Rules are also revised to clarify that behavioral health case management is not reimbursable for members who are enrolled in a Health Home. In addition, rules are modified to clarify that, unless otherwise specified in rule, reimbursement is not allowed for outpatient behavioral health services provided to members who are considered to be in "inpatient status."
Budget Impact: Budget neutral
Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Ms. Annette Mays

16-36 Program Integrity Audits and Records' Signatures — The proposed revisions to the Program Integrity Audits/Reviews policy clarify the Oklahoma Health Care Authority (OHCA) audit process by: explaining that the scope of audits may include examination for fraud, waste, and/or abuse of the SoonerCare program; establishing a clearly defined response due date for providers who want to request an informal reconsideration and/or formal appeal of audit findings; and by informing providers that overpayments identified through the audit process may be withheld from future payments if the provider fails to timely contest the underlying audit findings. Also, proposed revisions in Uniform Electronic Transaction Act policy set a consistent timeframe in which medical records must be authenticated, including those instances in which transcription occurs. In addition, the rules have been revised to improve reader comprehension, and make the language consistent with other OHCA administrative rules.
Budget Impact: Budget neutral
Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Mr. Traylor Rains-Sims

IX. New Business:

There was no new business to discuss

X. Future Meeting

July 20, 2017

XI. Adjournment

Dr. Crawford asked for a motion to adjourn. Motion was provided by Mr. Traylor Rains-Sims and seconded by Mr. Jeff Tallent. There was no dissent and the meeting was adjourned.

FINANCIAL REPORT

For the Seven Months Ended January 31,2017
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$2,498,702,031** or **.4% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,349,801,605 or .6% under** budget.
- The state dollar budget variance through January is a **positive $5,082,547.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		4.73
Administration		1.6
Revenues:		
Drug Rebate		.1
Taxes and Fees		(1.3)
Overpayments/Settlements		(.03)
Total FY 17 Variance	**$**	**5.1**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2017, For the Seven Month Period Ending January 31, 2017

REVENUES	FY17 Budget YTD	FY17 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 718,393,389	$ 718,393,389	$ -	0.0%
Federal Funds	1,342,489,822	1,334,724,024	(7,765,797)	(0.6)%
Tobacco Tax Collections	29,534,859	28,589,726	(945,133)	(3.2)%
Quality of Care Collections	45,666,521	45,465,752	(200,769)	(0.4)%
Prior Year Carryover	27,584,042	27,584,042	-	0.0%
Federal Deferral - Interest	55,372	55,372	-	0.0%
Drug Rebates	151,717,256	151,979,983	262,727	0.2%
Medical Refunds	20,547,524	20,467,831	(79,693)	(0.4)%
Supplemental Hospital Offset Payment Program	159,416,854	159,416,854	-	0.0%
Other Revenues	12,133,141	12,025,059	(108,082)	(0.9)%
TOTAL REVENUES	**$ 2,507,538,779**	**$ 2,498,702,031**	**$ (8,836,748)**	**(0.4)%**

EXPENDITURES	FY17 Budget YTD	FY17 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 32,594,778**	**$ 29,300,684**	**$ 3,294,094**	**10.1%**
ADMINISTRATION - CONTRACTS	**$ 49,904,180**	**$ 49,056,578**	**$ 847,602**	**1.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	23,903,429	23,423,540	479,889	2.0%
Acute Fee for Service Payments:				
Hospital Services	523,477,605	520,521,923	2,955,682	0.6%
Behavioral Health	11,493,595	11,411,024	82,571	0.7%
Physicians	232,836,418	231,981,767	854,651	0.4%
Dentists	73,861,831	72,974,416	887,415	1.2%
Other Practitioners	31,453,635	30,741,791	711,844	2.3%
Home Health Care	10,290,899	9,930,384	360,515	3.5%
Lab & Radiology	19,480,092	18,414,971	1,065,121	5.5%
Medical Supplies	27,117,746	27,044,788	72,958	0.3%
Ambulatory/Clinics	101,961,748	101,595,835	365,913	0.4%
Prescription Drugs	306,443,953	305,377,058	1,066,895	0.3%
OHCA Therapeutic Foster Care	(1)	(83,082)	83,081	0.0%
Other Payments:				
Nursing Facilities	324,857,380	324,889,635	(32,255)	(0.0)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	36,076,673	35,673,767	402,906	1.1%
Medicare Buy-In	96,421,283	96,411,833	9,450	0.0%
Transportation	37,894,730	37,675,357	219,373	0.6%
Money Follows the Person-OHCA	203,867	106,755	97,112	0.0%
Electonic Health Records-Incentive Payments	8,790,920	8,790,920	-	0.0%
Part D Phase-In Contribution	54,809,938	54,804,842	5,096	0.0%
Supplemental Hospital Offset Payment Program	353,179,907	353,179,907	-	0.0%
Telligen	6,576,912	6,576,912	-	0.0%
Total OHCA Medical Programs	**2,281,132,560**	**2,271,444,343**	**9,688,217**	**0.4%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,363,720,899**	**$ 2,349,801,605**	**$ 13,919,294**	**0.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 143,817,879**	**$ 148,900,426**	**$ 5,082,547**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2017, For the Seven Month Period Ending January 31, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 23,495,255	$ 23,416,919	$ -	$ 71,715	$ -	$ 6,621	$ -
Inpatient Acute Care	736,440,153	346,600,294	283,901	2,031,786	249,343,314	906,747	137,274,111
Outpatient Acute Care	254,936,605	170,514,994	24,269	2,464,326	79,741,297	2,191,720	
Behavioral Health - Inpatient	37,797,332	6,734,047	-	161,677	23,257,946	-	7,643,662
Behavioral Health - Psychiatrist	5,514,326	4,676,977	-	-	837,349	-	-
Behavioral Health - Outpatient	9,798,434	-	-	-	-	-	9,798,434
Behaviorial Health-Health Home	21,249,201	-	-	-	-	-	21,249,201
Behavioral Health Facility- Rehab	136,505,983	-	-	-	-	35,063	136,505,983
Behavioral Health - Case Management	10,539,268	-	-	-	-	-	10,539,268
Behavioral Health - PRTF	38,809,854	-	-	-	-	-	38,809,854
Residential Behavioral Management	10,905,394	-	-	-	-	-	10,905,394
Targeted Case Management	42,167,664	-	-	-	-	-	42,167,664
Therapeutic Foster Care	(83,082)	(83,082)	-	-	-	-	-
Physicians	267,127,195	229,514,264	33,892	(201,510)	-	2,433,611	35,346,938
Dentists	72,990,937	72,967,803	-	16,521	-	6,613	-
Mid Level Practitioners	1,549,377	1,533,836	-	14,182	-	1,359	-
Other Practitioners	29,438,073	28,894,217	260,379	231,477	-	52,000	-
Home Health Care	9,937,726	9,923,648	-	7,341	-	6,736	-
Lab & Radiology	18,841,086	18,286,165	-	426,115	-	128,805	-
Medical Supplies	27,205,836	25,446,411	1,581,727	161,048	-	16,650	-
Clinic Services	100,478,991	97,365,740	-	517,430	-	88,640	2,507,181
Ambulatory Surgery Centers	4,201,482	4,135,206	-	60,027	-	6,248	-
Personal Care Services	6,999,044	-	-	-	-	-	6,999,044
Nursing Facilities	324,889,635	199,259,735	125,629,900	-	-	-	-
Transportation	37,582,777	36,111,348	1,445,570	-	-	25,860	-
GME/IME/DME	88,748,342	-	-	-	-	-	88,748,342
ICF/IID Private	35,673,767	29,161,736	6,512,031	-	-	-	-
ICF/IID Public	8,960,079	-	-	-	-	-	8,960,079
CMS Payments	151,216,675	150,746,295	470,380	-	-	-	-
Prescription Drugs	312,879,553	304,049,869	-	7,502,495	-	1,327,189	-
Miscellaneous Medical Payments	92,580	92,580	-	-	-	-	-
Home and Community Based Waiver	117,911,394	-	-	-	-	-	117,911,394
Homeward Bound Waiver	47,909,486	-	-	-	-	-	47,909,486
Money Follows the Person	150,194	106,755	-	-	-	-	43,439
In-Home Support Waiver	14,678,692	-	-	-	-	-	14,678,692
ADvantage Waiver	107,696,830	-	-	-	-	-	107,696,830
Family Planning/Family Planning Waiver	2,268,111	-	-	-	-	-	2,268,111
Premium Assistance*	34,723,125	-	-	34,723,125	-	-	-
Telligen	6,576,912	6,576,912	-	-	-	-	-
Electronic Health Records Incentive Payments	8,790,920	8,790,920	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,167,595,204**	**$ 1,774,823,590**	**$ 136,242,048**	**$ 48,187,756**	**$ 353,179,906**	**$ 7,233,861**	**$ 847,963,105**

* Includes $34,496,747 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:

Other State Agencies

SFY 2017, For the Seven Month Period Ending January 31, 2017

		FY17 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	363,788,002
Federal Funds		526,992,091
TOTAL REVENUES	**$**	**890,780,093**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	117,911,394
Money Follows the Person		43,439
Homeward Bound Waiver		47,909,486
In-Home Support Waivers		14,678,692
ADvantage Waiver		107,696,830
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		8,960,079
Personal Care		6,999,044
Residential Behavioral Management		8,085,669
Targeted Case Management		37,145,980
Total Department of Human Services		**349,430,612**
State Employees Physician Payment		
Physician Payments		35,346,938
Total State Employees Physician Payment		**35,346,938**
Education Payments		
Graduate Medical Education		50,325,402
Graduate Medical Education - Physicians Manpower Training Commission		3,652,219
Indirect Medical Education		33,086,772
Direct Medical Education		1,683,949
Total Education Payments		**88,748,342**
Office of Juvenile Affairs		
Targeted Case Management		1,489,415
Residential Behavioral Management		2,819,725
Total Office of Juvenile Affairs		**4,309,140**
Department of Mental Health		
Case Management		10,539,268
Inpatient Psychiatric Free-standing		7,643,662
Outpatient		9,798,434
Health Homes		21,249,201
Psychiatric Residential Treatment Facility		38,809,854
Rehabilitation Centers		136,505,983
Total Department of Mental Health		**224,546,402**
State Department of Health		
Children's First		1,038,644
Sooner Start		642,582
Early Intervention		2,231,381
Early and Periodic Screening, Diagnosis, and Treatment Clinic		370,656
Family Planning		75,730
Family Planning Waiver		2,180,936
Maternity Clinic		2,709
Total Department of Health		**6,542,638**
County Health Departments		
EPSDT Clinic		428,495
Family Planning Waiver		11,445
Total County Health Departments		**439,940**
State Department of Education		**101,242**
Public Schools		**161,002**
Medicare DRG Limit		**130,345,215**
Native American Tribal Agreements		**1,062,739**
Department of Corrections		**729,651**
JD McCarty		**6,199,245**
Total OSA Medicaid Programs	**$**	**847,963,105**
OSA Non-Medicaid Programs	**$**	**39,550,037**
Accounts Receivable from OSA	**$**	**(3,266,950)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2017, For the Seven Month Period Ending January 31, 2017

REVENUES	FY 17 Revenue
SHOPP Assessment Fee	$ 159,255,868
Federal Draws	212,855,062
Interest	58,176
Penalties	102,810
State Appropriations	(22,650,000)
TOTAL REVENUES	$ 349,621,916

EXPENDITURES	Quarter	Quarter	Quarter	FY 17 Expenditures
Program Costs:	7/1/16 - 9/30/16	10/1/16 - 12/31/16	1/1/17 - 3/31/17	
Hospital - Inpatient Care	76,250,540	79,873,814	93,218,960	$ 249,343,314
Hospital -Outpatient Care	27,213,505	28,255,818	24,271,974	79,741,297
Psychiatric Facilities-Inpatient	6,661,677	6,897,421	9,698,849	23,257,946
Rehabilitation Facilities-Inpatient	257,683	269,198	310,468	837,349
Total OHCA Program Costs	110,383,405	115,296,250	127,500,252	$ 353,179,907
Total Expenditures				$ 353,179,907

CASH BALANCE	$ (3,557,991)

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

SFY 2017, For the Seven Month Period Ending January 31, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 45,443,654	$ 45,443,654
Interest Earned	22,098	22,098
TOTAL REVENUES	**$ 45,465,752**	**$ 45,465,752**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 123,490,464	$ 48,914,573	
Eyeglasses and Dentures	160,576	63,604	
Personal Allowance Increase	1,978,860	783,826	
Coverage for Durable Medical Equipment and Supplies	1,581,727	626,522	
Coverage of Qualified Medicare Beneficiary	602,441	238,627	
Part D Phase-In	470,380	186,318	
ICF/IID Rate Adjustment	3,015,792	1,194,555	
Acute Services ICF/IID	3,496,239	1,384,860	
Non-emergency Transportation - Soonerride	1,445,570	572,590	
Total Program Costs	**$ 136,242,048**	**$ 53,965,475**	**$ 53,965,475**
Administration			
OHCA Administration Costs	$ 310,152	$ 155,076	
DHS-Ombudsmen	79,036	79,036	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 389,188**	**$ 234,112**	**$ 234,112**
Total Quality of Care Fee Costs	**$ 136,631,236**	**$ 54,199,587**	
TOTAL STATE SHARE OF COSTS			**$ 54,199,587**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2017, For the Seven Month Period Ending January 31, 2017

REVENUES	FY 16 Carryover	FY 17 Revenue	Total Revenue
Prior Year Balance	$ 5,199,281	$ -	$ 3,102,480
State Appropriations	(2,000,000)	-	-
Tobacco Tax Collections	-	23,514,830	23,514,830
Interest Income	-	71,893	71,893
Federal Draws	246,145	21,633,855	21,633,855
TOTAL REVENUES	**$ 3,445,426**	**$ 45,220,578**	**$ 48,323,058**

EXPENDITURES		FY 16 Expenditures	FY 17 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 34,496,747	$ 34,496,747
	College Students/ESI Dental		226,379	89,669
Individual Plan				
	SoonerCare Choice		$ 69,123	$ 27,380
	Inpatient Hospital		2,026,701	802,776
	Outpatient Hospital		2,430,198	960,900
	BH - Inpatient Services-DRG		154,041	60,908
	BH -Psychiatrist		-	-
	Physicians		(168,562)	(66,650)
	Dentists		16,411	6,489
	Mid Level Practitioner		14,182	5,608
	Other Practitioners		227,686	90,027
	Home Health		5,500	2,175
	Lab and Radiology		415,346	164,228
	Medical Supplies		153,008	60,499
	Clinic Services		506,185	200,146
	Ambulatory Surgery Center		57,355	22,678
	Prescription Drugs		7,366,945	2,912,890
	Miscellaneous Medical		-	-
	Premiums Collected		-	(318,419)
Total Individual Plan			**$ 13,274,118**	**$ 4,931,635**
	College Students-Service Costs		**$ 190,512**	**$ 75,462**
Total OHCA Program Costs			**$ 48,187,756**	**$ 39,593,512**
Administrative Costs				
	Salaries	$ 32,930	$ 1,186,205	$ 1,219,135
	Operating Costs	15,971	95,033	111,004
	Health Dept-Postponing	-	-	-
	Contract - HP	294,045	1,410,374	1,704,419
Total Administrative Costs		**$ 342,946**	**$ 2,691,612**	**$ 3,034,558**
Total Expenditures				**$ 42,628,070**
NET CASH BALANCE		**$ 3,102,480**		**$ 5,694,988**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2017, For the Seven Month Period Ending January 31, 2017

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	$ 469,162	$ 469,162
TOTAL REVENUES	**$ 469,162**	**$ 469,162**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 6,621	$ 313	
Inpatient Hospital	906,747	42,889	
Outpatient Hospital	2,191,720	103,668	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	2,433,611	115,110	
Dentists	6,613	313	
Mid-level Practitioner	1,359	64	
Other Practitioners	52,000	2,460	
Home Health	6,736	319	
Lab & Radiology	128,805	6,092	
Medical Supplies	16,650	788	
Clinic Services	88,640	4,193	
Ambulatory Surgery Center	6,248	296	
Prescription Drugs	1,327,189	62,776	
Transportation	23,107	1,093	
Miscellaneous Medical	2,753	130	
Total OHCA Program Costs	**$ 7,198,799**	**$ 340,503**	
OSA DMHSAS Rehab	$ 35,063	$ 1,658	
Total Medicaid Program Costs	**$ 7,233,861**	**$ 342,162**	
TOTAL STATE SHARE OF COSTS			**$ 342,162**

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

SFY 2018
Appropriations Scenarios

Presentation to the Medical Advisory Committee

May 18, 2017

Oklahoma HealthCare Authority

CUTS TO PROGRAM IN LAST 6 SFYs

- **2010 – 3.25% provider rate cut**
- **2015 – 7.75% provider rate cut**
- **2016 – 3% provider rate cut**

  Today's physician reimbursement rate is 86.57% of the Medicare physician fee schedule.
- **More than $500 million has been cut from the program since SFY 2010**

Oklahoma HealthCare Authority

REGIONAL PHYSICIAN PROVIDER RATES

2016 Medicaid to Medicare Physician Fee Schedule

Arkansas = .80

Colorado = .72

Kansas = .78

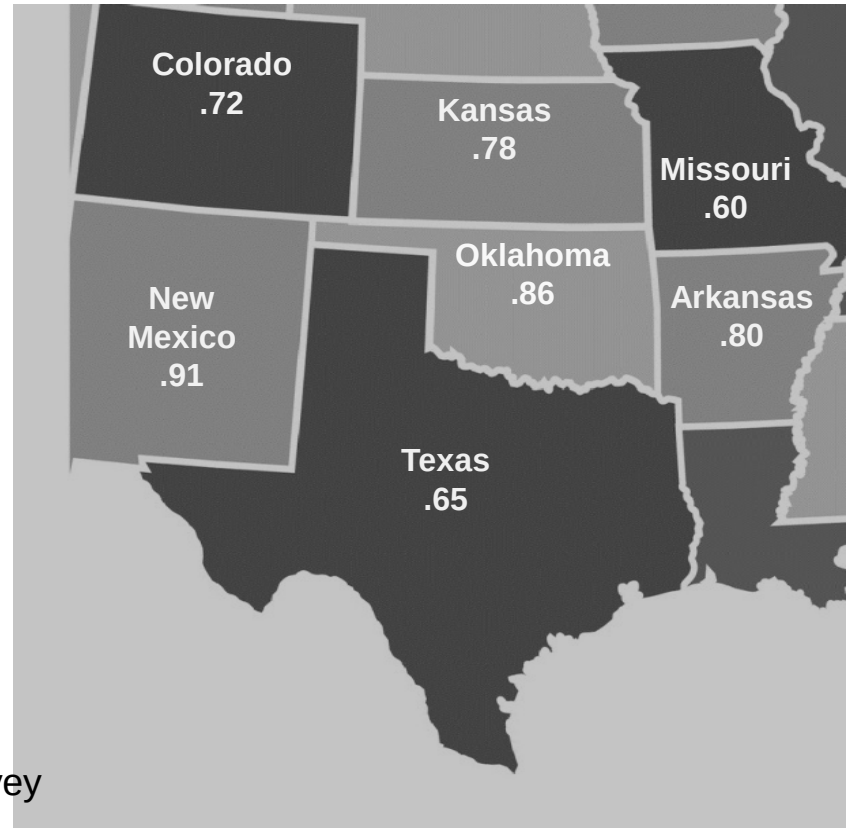
Louisiana = .71

Missouri = .60

New Mexico = .91

Oklahoma = .86

Texas = .65



Source: Urban Institute 2014 Medicaid Physician Survey

Oklahoma HealthCare Authority

SFY 2018 Appropriation Scenarios

SFY 2017 Appropriation base revised (after March 2017 revenue failure) $986.4M

State savings from 1% provider rate reduction $8.6M

If Congress extends ACA-CHIP funding (94%)

% Cut	Appropriation reduction (state only)	SFY18 Appropriation need	Total State Reduction	Total Reduction (state & federal)	Provider rate reduction equivalent
0% (Flat)	**-**	**$69M**	**$69M**	**$167M**	**8.0%**
5%	**$50M**	**$69M**	**$118M**	**$288M**	**13.7%**
10%	**$99M**	**$69M**	**$168M**	**$408M**	**19.5%**
14.5%	**$143M**	**$69M**	**$212M**	**$515M**	**24.6%**
15%	**$148M**	**$69M**	**$217M**	**$527M**	**25.2%**

*The ACA-CHIP funding will expire on 9/30/2017. If Congress reauthorizes the ACA funding match, OHCA will need **$69M** to maintain today's program and rates.*

If Congress does not extend CHIP funding

% Cut	Appropriation reduction (state only)	SFY18 Appropriation need	Total State Reduction	Total Reduction (state & federal)	Provider rate reduction equivalent
0% (Flat)	**-**	**$118M**	**$118M**	**$288M**	**13.7%**
5%	**$50M**	**$118M**	**$168M**	**$408M**	**19.5%**
10%	**$99M**	**$118M**	**$217M**	**$529M**	**25.3%**
14.5%	**$143M**	**$118M**	**$261M**	**$636M**	**30.4%**
15%	**$148M**	**$118M**	**$266M**	**$648M**	**30.9%**

*If Congress does not reauthorize the ACA CHIP funding match, OHCA will need **$118M** to maintain today's program and rates.*

Access Monitoring Review Plan Timeline

- OHCA submitted the initial Access Monitoring Review Plan (AMRP) to CMS on September 28, 2016 and received verbal approval on December 15, 2016.

- OHCA will review and update the federally required categories of services within the AMRP annually as well as post for public review on the public website.

- An updated AMRP will be submitted to CMS every three years.

Oklahoma HealthCare Authority

Access Monitoring Review Plan Service Categories

- Primary care services (including those provided by a physician, federally-qualified health center, clinic, or dental provider)
- Physician specialist services (e.g., cardiology)
- Behavioral health services (including mental health and substance use disorder)
- Pre- and post-natal obstetric services, including labor and delivery
- Home health services

Oklahoma HealthCare Authority

Access to Care Analysis

- Proposed reductions of provider payment rates must demonstrate sufficient access to care by comparing the following:
  - total number of providers/provider specialties;
  - total number of Medicaid eligible beneficiaries; and
  - increase/decrease of a services rendered.
- Effect on Access to Care
  - Monitoring will be informed by public review and will be conducted no less than annually.
  - If access deficiencies arise, the state must submit a corrective action plan to remediate diminished access within 12 months.

Oklahoma HealthCare Authority

OHCA Board Meeting
May 25, 2017
(Mar 2017 Data)

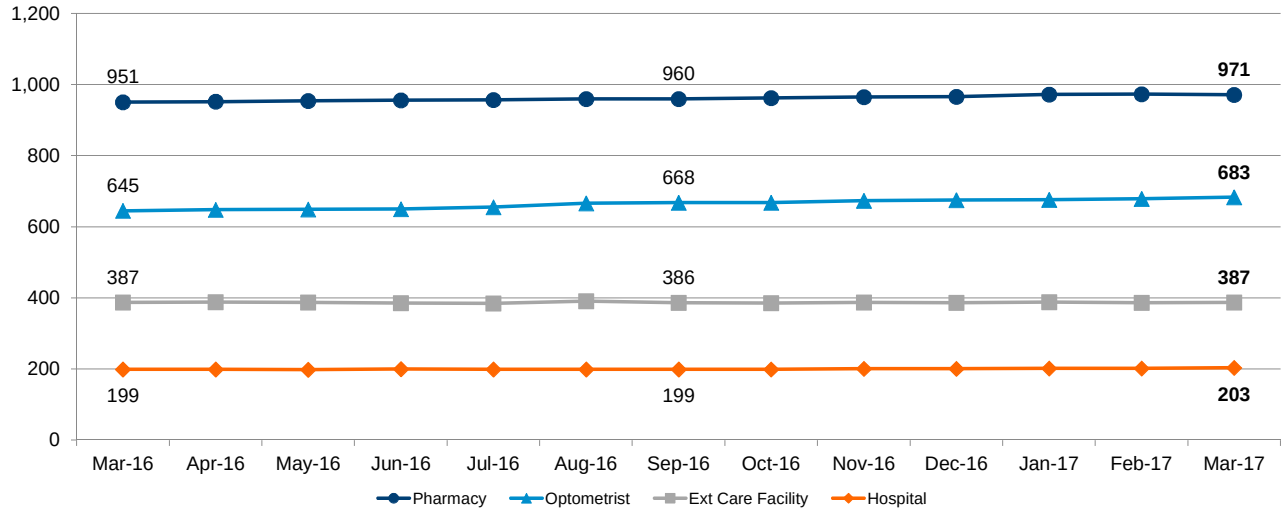
SOONERCARE ENROLLMENT/EXPENDITURES

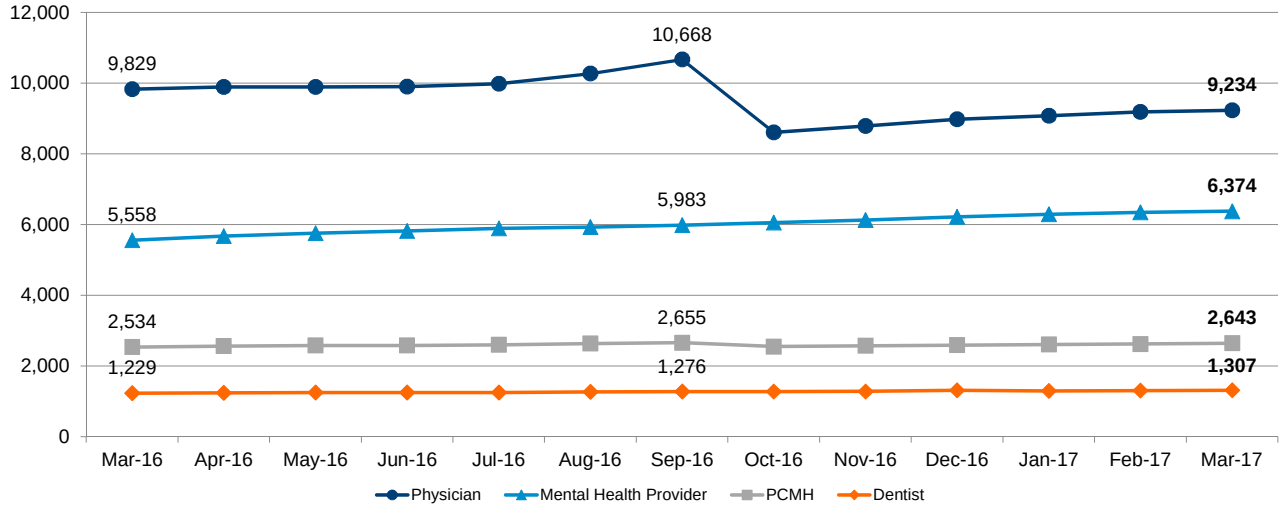
Delivery System			Enrollment March 2017	Children March 2017	Adults March 2017	Enrollment Change	Total Expenditures March 2017	PMPM March 2017	Forecasted Mar 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**555,806**	**459,256**	**96,550**	**-2,747**	**$157,294,244**		
	Lower Cost	*(Children/Parents; Other)*	511,870	445,287	66,583	-3,074	$118,209,811	$231	$207
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,936	13,969	29,967	327	$39,084,433	$890	$861
SoonerCare Traditional			**232,685**	**87,032**	**145,653**	**-2**	**$250,375,771**		
	Lower Cost	*(Children/Parents; Other)*	119,841	82,143	37,698	117	$74,951,383	$625	$443
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	112,844	4,889	107,955	-119	$175,424,388	$1,555	$1,274
SoonerPlan			**34,264**	**2,783**	**31,481**	**-438**	**$389,368**	$11	$8
Insure Oklahoma			**19,372**	**573**	**18,799**	**-1,312**	**$7,630,498**		
	Employer-Sponsored Insurance		14,463	352	14,111	-1,120	$4,993,912	$345	$357
	Individual Plan		4,909	221	4,688	-192	$2,636,586	$537	$414
TOTAL			**842,127**	**549,644**	**292,483**	**-4,499**	**$415,689,880**		

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

IN-STATE CONTRACTED PROVIDERS

Total In-State Providers: 34,416 (+246) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**





*Decrease in Physician count is due to contract renewal. Decrease during contract renewal period is typical during all renewal periods.

PROGRAM INTEGRITY

ARE ALL PROVIDERS AUDITED?

*Federal Regulations (42 CFR 455.15) state that if the agency receives a complaint of fraud / abuse from any source **OR** identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full review.*

HOW ARE AUDITS INITIATED?

- **Referrals**
- **Peer-to-Peer Comparisons**
- **Data-Mining**

REFERRALS

- **Patients**
- **Family members**
- **Employees**
- **Other agencies**
- **Community members**

PEER TO PEER COMPARISON

Software compares all claims of “like” peers

Looks for outliers – billers outside the norm

- More high level claims?
- More claims per patient?
- More patients?
- Billing for services / codes that peers don’t normally bill for?

DATA-MINING

- **Utilizes large amounts of claims data**
- **Ideas?**
  - Fraud Alerts
  - Training Courses
  - Issues in Other States
  - OIG Workplan
  - Completed Audits

Josh Richards

Director of Program Integrity

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OHCA MEDICAL ADVISORY COMMITTEE MEETING
LEGISLATIVE UPDATE, MAY 18, 2017

As of May 11, 2017, following the April 27th deadline, the Oklahoma State Legislature is considering 642 active bills. Over 1,700 bills that have been introduced this session have fallen dormant for the remainder of the 2017 session. OHCA is currently tracking 43 bills, of which two are pending OHCA request bills.

OHCA REQUEST BILLS

- HB 1579 – Rep. Chad Caldwell and Sen. Stephanie Bice – Data exchange with DPS to verify member identify;
  - Governor Signed – *5/1/17*

- SB 773 – Sen. Kim David and Rep. Glen Mulready – Foster children care coordination model;
  - Governor Signed – *5/3/17*

- SB 819 – Sen. Frank Simpson and Rep. Pat Ownbey – Property liens;
  - Sent to Governor – *5/8/17*

- SB 828 – Sen. A.J. Griffin and Rep. Chad Caldwell – Creation of nursing home UPL revolving fund;
  - 3rd Reading, House Engrossed – *4/27/17*
  - Senate Read House Amendments – *5/1/17*

- *SB 729 – Sen. Frank Simpson and Rep. Pat Ownbey – Medicaid super lien;*
  - *Failed Deadline – 3/2/17*
- *SB 798 – Sen. Rob Standridge and Rep. Chris Kannady – OHCA provider audit appeals;*
  - *Failed Deadline – 3/23/17*

UPCOMING DEADLINES FOR THE 2017 LEGISLATIVE SESSION

May 26, 2017 **Sine Die Adjournment – no later than 5:00 p.m.**

BUDGET UPDATE

OHCA is currently tracking the cigarette tax bill, HB 2372. This bill would generate $92.5M for OHCA for FY18. The bill passed House and Senate budget committees but has not been heard on the floor of either chamber. Legislators must approve tax measures by May 19th as they cannot do so during the final week of session.

OHCA needs $69M on top of what was received last year to maintain current services. OHCA is also asking for an additional $52M for SoonerHealth+. The Children's Health Insurance Program has not been reauthorized by Congress (although we expect it will be) which is another potential loss of $49M in federal funds.

OHCA continues to work with state and federal policymakers to make sure our providers are not adversely impacted by potential reductions.

May MAC
Proposed Rule Amendment Summaries

A face to face tribal consultation regarding the following proposed changes was held Tuesday, March 7, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA).

Rule changes within work folders 17-01 and 17-02 were posted on the OHCA public website for a 30-day comment period from March 7, 2017 through April 6, 2017. Rule changes within work folders 17-04 A&B were posted on the OHCA public website for a 30-day comment period from April 17, 2017 through May 18, 2017.

17-01 Policy Revision to Comply with Fairness in Medicaid Supplemental Needs Trusts Act — The proposed revisions are necessary in order to comply with federal regulation. The Fairness in Medicaid Supplemental Needs Trusts adds language into the Social Security Act to give mentally competent disabled individuals the same right to create an exempt trust as a parent, grandparent, guardian, or court. The Fairness Act will apply to trusts established on or after December 13, 2016. Other requirements of these types of trusts, which are exempt from Medicaid resource limits, remain unchanged.
Budget Impact: Budget neutral

17-02 Self-Employment Language in Insure Oklahoma — The proposed revisions to the Insure Oklahoma Individual Plan policy strengthen program integrity. Revisions make it incumbent upon the self-employed applicant to verify self-employment by completing and submitting certain documentation. Revisions will help ensure that self-employed applicants are engaged in routine, for-profit activity, in accordance with federal Internal Revenue Service guidelines.
Budget Impact: Budget neutral

17-04 A&B Money Follows the Person Demonstration for Psychiatric Residential Treatment Facility Wraparound Services — The proposed revisions to the Living Choice rules add a fourth population to be served in the Money Follows the Person (MFP) demonstration. The intent of the change is to develop an implementation plan to transition eligible individuals from Psychiatric Residential Treatment Facilities (PRTF) back into the community. Oklahoma's MFP Demonstration for PRTF transitioning will focus on transitioning youth 16 to 18 who have been in an inpatient psychiatric residential facility for 90 or more days during an episode of care. The individuals must meet criteria for Level 4 on the Individual Client Assessment Record and show critical impairment on a score of 25 and above on the Problems Subscale, or a score of 44 and below on the Functioning Subscales. Additionally, the individuals will be eligible for transitional and community-based services and medications under Oklahoma’s Living Choice Program. Services will be provided in accordance with an individualized plan of care under the direction of appropriate service providers. Finally, revisions replace the term Intermediate Care Facility for Mentally Retarded with Intermediate Care Facility for Individuals with Intellectual Disabilities.
Budget Impact: The budget impact is approximately $695,739 total federal dollars, $174,261 state dollars. State share will be paid by the ODMHSAS.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.6. Trust accounts

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, ~~etc.,~~ or the Bureau of Indian Affairs (BIA).

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the ~~OKDHS~~Oklahoma Department of Human Services(OKDHS) State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms**. The following words and terms, when used in this paragraph, have the following meaning, unless the context clearly indicates otherwise:

(A) **Beneficiary**. Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal**. Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers**. Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions**. Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor)**. Grantor (trustor/settlor) means the individual who establishes the trust by

transferring certain assets.

(F) **Irrevocable trust**. Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust**. Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary**. Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust**. Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary**. Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust**. Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee**. Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993**. The rules found in (A) - (C) of this paragraph apply to trust

accounts established on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) **Medicaid Qualifying Trust (MQT).** A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts

created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to 12 O.S. 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device**. MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment**. For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions

do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources**. If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts**. Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(i) the individual;

(ii) the individual's spouse;

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

(iv) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the 60 months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

(A) A trust containing the assets of a disabled individual under the age of 65 which was established for the benefit of such individual by the individual, parent, grandparent,

legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(i) The trust may only contain the assets of the disabled individual.

(ii) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority.

(iii) Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(iv) The exception for the trust continues after the disabled individual reaches age 65. However, any addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65; therefore, those assets are not subject to the exemption.

(v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of 65.

(vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

(vii) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.

(viii) The OKDHS Form 08MA018E, Supplemental Needs

Trust, is an example of the trust. Workers may give the sample form to the member or his/her representative to use or for their attorney's use.

(ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services (HR&MS) explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services notifies ~~OHCA/TPL~~Oklahoma Health Care Authority/Third Party Liability(OHCA/TPL) to initiate the recovery process.

(B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1 Schedule VIII.B) but less than the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).

(ii) The Trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.

(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.

(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to 3% of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason and effective date for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the Oklahoma Department of Human Services and may not be amended without the permission of the Oklahoma Department of Human Services;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;

(vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of 30% of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of individual Indians in trust or restricted lands are not considered in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 11. INSURE OKLAHOMA IP

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma IP eligibility requirements

(a) Oklahoma employed working adults not eligible to participate in an employer's qualified benefit plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. ~~Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, must be considered self-employed as defined under federal and/or state law, or must be considered unemployed as defined under state law.~~ Applicants, unless a qualified college student, must be: considered "employed" in accordance with State law, including, but not limited to, 40 O.S. § 1-210; engaged in routine, for-profit activity, if self-employed; or considered "unemployed" in accordance with State law, including, but not limited to 40 O.S. § 1-217. Applicants cannot obtain IP coverage if they are eligible for ESI.

(b) The eligibility determination will be processed within 30 days from the date the complete application is received. The applicant will be notified of the eligibility decision.

(c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in 317:45-11-22, at the time he/she completes application;

(2) be a US citizen or alien as described in 317:35-5-25;

(3) be an Oklahoma resident;

(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma IP benefits;

(5) be not currently enrolled in, or have an open application for SoonerCare or Medicare;

(6) be age 19 through 64;

(7) make premium payments by the due date on the invoice;

(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a) (1)-(2);

(9) be not currently covered by a private insurance policy or plan; and

(10) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) If employed and working for an approved Insure Oklahoma employer who offers a qualified benefit plan, the applicant must

meet the requirements in subsection (c) of this Section and:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants do not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits;

(2) be ineligible for participation in their employer's qualified benefit plan due to number of hours worked.

(e) If employed and working for an employer who does not offer a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(1) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(2) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(2) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a)(1)-(2).

(3) must verify self-employment by completing and submitting to Insure Oklahoma the Self-Employment Attestation Form. In addition,

(A) for any applicant who filed a Federal tax return for the tax year immediately preceding the date of application, he or she must provide a copy of such tax return with all supporting schedules and forms, or

(B) for any applicant exempt from filing a Federal tax return for the previous tax year in accordance with Federal law, including, but not limited to, 26 C.F.R. § 1.6017-1, he or she must submit a completed 12-Month Profit and Loss Worksheet to Insure Oklahoma, as well as any other information requested by Insure Oklahoma that could reasonably be used to substantiate the applicant's regular, for-profit business activity.

(g) If unemployed seeking work, the applicant must meet the requirements in subsection(c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(3) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits. Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) A OESC eligibility letter;

(B) A OESC weekly unemployment payment statement, or;

(C) A bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Applicants may need to verify eligibility of their enrollment in the Ticket to Work program.

(3) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(4) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.
(j) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.
(k) College students may enroll in the Insure Oklahoma IP program as dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA). College students must also provide a copy of their current student schedule to prove full-time student status.
(l) Any misleading or false representation, or omission of any material fact or information required or requested by OHCA as part of the Insure Oklahoma application process, may result in, among other things, closure of eligibility pursuant to OAC 317:45-11-27.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 113. LIVING CHOICE PROGRAM

317:30-5-1207. Benefits for members ages sixteen (16) through eighteen (18) in a psychiatric residential treatment facility

(a) Living Choice program participants, ages sixteen (16) through eighteen (18), may receive a range of necessary home and community based services for one year after transitioning to the community from a psychiatric residential treatment facility (PRTF) setting. In order to be eligible for the Living Choice program if they meet the following criteria:

(1) Have been in a PRTF facility for 90 or more days during an episode of care;

(2) Meet level 4 criteria on the Individual Client Assessment;

(3) Show critical impairment score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales; and

(4) May be in the custody of Oklahoma's Child Welfare Agency or Juvenile Justice Agency.

(b) Services must be billed using the appropriate Healthcare Common Procedure Code System and must be medically necessary.

(c) All services must be necessary for the individual to live successfully in the community, must be documented in the individual care plan and require prior authorization.

(d) Services that may be provided to members transitioning from a PRTF are found in OAC 317:30-5-252.

(e) Reimbursement will be for a monthly care coordination payment upon successful submission of a claim for one or more of the covered services listed in OAC 317:30-5-252.

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

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

(a) Adults with disabilities or long-term illnesses, members with intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in ~~an institution (nursing facility or public ICF/MR)~~a nursing facility or public Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for at least 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

(8) He/she must not be a resident of a nursing facility or ~~ICF/MR~~ICF/IID in lieu of incarceration.

(b) Youth ages sixteen (16) through eighteen (18) are eligible to transition back into the community from a psychiatric residential treatment facility (PRTF) through the Living Choice program if they meet the following criteria:

(1) Have been in a PRTF facility for 90 or more days during an episode of care;

(2) Meet Level 4 criteria on the Individual Client Assessment;
(3) Show critical impairment score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales; and
(4) May be in the custody of Oklahoma's Child Welfare Agency or Juvenile Justice Agency.

317:35-23-3. Participant disenrollment

(a) A member is disenrolled from the program if he/she:
(1) is admitted to a hospital, nursing facility, ~~ICF/MR,~~ICF/IID, residential care facility or behavioral health facility for more than 30 consecutive days;
(2) is incarcerated;
(3) is determined to no longer meet SoonerCare financial eligibility for home and community based services;
(4) determined by the Social Security Administration or OHCA Level of Care Evaluation Unit to no longer have a disability that qualifies for services under the Living Choice program; or
(5) moves out of state.

(b) Payment cannot be made for an individual who is in imminent danger of harm to self or others.

2018-2018 SoonerCare Choice and Insure Oklahoma 1115(a) Demonstration Waiver Extension Request – Pursuant to 42 CFR §431.408, the Oklahoma Health Care Authority (OHCA) is providing notice of its plan to submit an update to its current renewal application for the SoonerCare Choice and Insure Oklahoma 1115(a) waiver to the Centers for Medicare and Medicaid Services (CMS). The OHCA is requesting an additional year extension of the waiver for the period January 1, 2018, to December 31, 2018. The OHCA plans to extend the demonstration with one change to clarify and define payment methodology. The State will provide clarification for supplemental payments to State of Oklahoma teaching Universities. This will reflect value based purchasing. The OHCA welcomes comments on the continuation of the SoonerCare Choice and Insure Oklahoma programs. The existing waiver application is currently posted on the OHCA website. It can be found on the Policy Change Blog and the Native American Consultation Page. The OHCA will be accepting comments/feedback for the waiver application until June 24, 2017.

Proposed 1115 Waiver Amendment – The Oklahoma Health Care Authority (OHCA) proposes a n amendment to the 1115(a) demonstration waiver to. Pursuant to House Bill 1566 passed by the Oklahoma Legislature, the OHCA has issued a Request For Proposal (RFP) for a care coordination model for the Aged, Blind and Disabled (ABD) populations. The outcome will allow for a fully capitated, statewide model of care coordination to best serve Oklahoma Medicaid's Aged, Blind and Disabled (ABD) population known as SoonerHealth+. The ABD population currently receiving health care services under the 1115(a) demonstration will be added as a separate program under the 1115 waiver to transition eligibility to the SoonerHealth+ program once implemented. The benefits for the ABD population will be delivered in a new program called SoonerHealth+. These individuals will receive all benefits including care coordination services through a fully capitated managed care delivery model.