
POLICY TRANSMITTAL NO. 06-38	DATE: SEPTEMBER 7, 2006
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS & POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:2-1-1 through 2-1-13; 35-3-2; 35-15-8.1; 35-19-16; and
45-1-2; 45-3-1; 45-7-1; 45-7-2; 45-7-5; and 45-9-1.

EXPLANATION: **Policy revisions were approved by the Commission and the Governor as required by the Administrative Procedures Act.**

OHCA appeals rules are revised to accurately reflect the agency which will hear various employer and employee eligibility appeals.

Oklahoma Employer and employee Partnership for Insurance Coverage (O-EPIC) rules are revised to incorporate several changes which were requested by Oklahoma small business owners at the time of implementation of the program.

Original signed on 8-18-06

Mary Stalnaker, Director
Family Support Services Division

Sharon Neuwald, Coordinator
Office of Legislative Relations and Policy

WF # 06-L (DT)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS as the rulemaking agency; the “2” specifies the Chapter number; and the “1” specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-6392.

<u>REMOVE</u>	<u>INSERT</u>
317:2-1-1	317:2-1-1, 1 page only, revised 3-1-06
317:2-1-2	317:2-1-2, pages 1-3, revised 3-1-06
317:2-1-2.1	-----
317:2-1-2.2	-----
317:2-1-2.3	-----
317:2-1-4	-----
-----	317:2-1-5, pages 1-3, issued 3-1-06
-----	317:2-1-6, 1 page only, issued 3-1-06
-----	317:2-1-7, pages 1-2, issued 3-1-06
-----	317:2-1-8, 1 page only, issued 3-1-06
-----	317:2-1-9, 1 page only, issued 3-1-06
-----	317:2-1-10, pages 1-3, issued 3-1-06
-----	317:2-1-11, pages 1-2, issued 3-1-06
-----	317:2-1-12, pages 1-3, issued 3-1-06
-----	317:2-1-13, 1 page only, issued 3-1-06
317:35-3-2	317:35-3-2, pages 1-4, revised 3-1-06

REMOVE

317:35-15-8.1

317:35-19-16

317:45-1-2

317:45-3-1

317:45-7-1

317:45-7-2

317:45-7-5

317:45-9-1

INSERT

317:35-15-8.1, pages 1-3, revised 3-1-06

317:35-19-16, 1 page only, revised 3-1-06

317:45-1-2, pages 1-2, revised 2-1-06

317:45-3-1, 1 page only, revised 2-1-06

317:45-7-1, pages 1-2, revised 2-1-06

317:45-7-2, 1 page only, revised 2-1-06

317:45-7-5, 1 page only, revised 2-1-06

317:45-9-1, pages 1-2, revised 2-1-06

317:2-1-1. Purpose

The purpose of this Chapter is to describe the different types of grievances addressed by the Oklahoma Health Care Authority (OHCA). The rules explain the step by step processes that must be followed by a party seeking redress from the OHCA. All hearings on eligibility issues for recipients are conducted by the Oklahoma Department of Human Services, and are not contained in this Chapter. Hearings will not be granted when the sole issue to be determined is a Federal or State law requiring an automatic change adversely affecting some or all recipients.

317:2-1-2. Appeals**(a) Recipient process overview.**

(1) The appeals process allows a recipient to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the recipient files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal).

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. ' 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Recipient appeals are first reviewed by a three person program panel that may or may not contact the recipient [Section OAC 317:2-1-5]. The recipient may then request a fair hearing before the ALJ. The recipient must appear at this hearing and it is conducted according to Section OAC 317:2-1-5. The ALJ's decision may be appealed to the CEO, which is a record review at which the parties do not appear (Section OAC 317:2-1-13).

(7) Recipient appeals are to be decided within 90 days from the date OHCA receives the recipient's timely request for a fair hearing of the program panel's decision unless the recipient waives this requirement. [Title 42 U.S.C. Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) Provider process overview.

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(D) A decision will be rendered by the ALJ within 45 days of the close of all evidence in the case.

(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Recipient Appeals:

(A) Discrimination complaints regarding the Medicaid program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to dis-enroll recipient from provider's SoonerCare panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

(D) Petitions for Rulemaking;

(E) Appeals of insureds participating in O-EPIC which are authorized by OAC 317:45-9-8(a);

(F) Appeals to the decision made by the Business Contracts manager related to Purchasing as found at OAC 317:10-1-5, 317:10-1-13, 317:25-1-5, 317:25-1-12, and other appeal rights granted by contract;

(G) Drug rebate appeals;

(H) Nursing home contracts which are terminated, denied, or non-renewed; and

(I) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions.

317:2-1-5. Hearing procedures

(a) Program Panel Hearings. Program Panel Hearings will be by a Program Panel, except in the case of tax warrant intercept appeals and proposed administrative sanction appeals [refer to OAC 317:2-1-2(c)].

(1) The Program Panel will be composed of three or more members selected by the ALJ.

(2) The Program Panel may conduct a paper review of the complaint, or, at their option, hold a personal interview with the appellant to discuss the complaint. The Panel has the power to gather information it finds necessary from any available source, and thereafter, render a decision.

(3) The Panel must complete their paper review or conduct their formal personal interview and issue a majority decision within 25 days of the date stamped on the request for hearing.

(4) The Panel's decision will be in writing and will be signed by each of the Panel members. The decision will contain a summary of the complaint and an explanation of the reasoning of the Panel in making their decision. A copy of the decision will be sent to the member outlining the right to appeal the decision. Any appeal of the Panel decision must be instituted within 20 days of the mailing of the adverse ruling.

(5) A copy of the decision will be forwarded to the docket clerk.

(6) Appeal from a decision of the Program Panel will be heard by the Administrative Law Judge. A decision will be rendered by the Administrative Law Judge within forty days of the appeal to the ALJ.

(b) Administrative Law Judge.

(1) Hearings will be conducted in an informal manner without formal rules of evidence or procedure.

(2) No party is required to be represented by an attorney. Recipients may represent themselves or authorize another party to represent them. A person or entity desiring to represent a recipient must provide documentation of the consent of the recipient to be represented by that person or entity. An appeal

will be rejected without documentation of representation. Individuals appearing for corporate entities will be deemed to be authorized to represent the corporation in a hearing.

(3) The docket clerk will send the Appellant and any other necessary party notice which states the hearing location, date, and time.

(4) The OHCA Administrative Law Judge or designee may:

(A) Rule on any requests for extension of time;

(B) Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;

(C) Require the parties to state their positions concerning the various issues in the proceeding;

(D) Require the parties to produce for examination those relevant witnesses and documents under their control;

(E) Rule on motions and other procedural items;

(F) Regulate the course of the hearing and conduct of the participants;

(G) Establish time limits for the submission of motions or memoranda;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing

as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Reconsider or rehear a matter for good cause shown; and

(P) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.

(5) The burden of proof during the hearing will be upon the appellant and the ALJ will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court. Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(6) Parties may file preliminary motions in the case. Any such motions must be filed within 15 calendar days prior to the hearing date. Response to preliminary motions must be made within 7 calendar days of the date the motion is filed with OHCA. Preliminary motions will be ruled upon 3 days prior to the hearing date.

(7) In any case in which a recipient requests a continuance, OHCA will not be prejudiced to complete the case within 90 days.

317:2-1-6. Other grievance procedures and processes

Other grievance procedures and processes include those set out in OAC 317:2-1-7 [Surveillance, Utilization and Review System (SURS) and Program Integrity Audits/Reviews Appeals]; OAC 317:2-1-8 (Nursing Home Provider Contract Appeals); OAC 317:2-1-9 [OHCA's Designated Agent's Appeal Process for Behavioral Health Services]; OAC 317:2-1-10 (Drug Rebate Appeal Process); OAC 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; and OAC 317:2-1-12 (For Cause Provider Contract Suspension/Termination Appeals Process).

317:2-1-7. Surveillance, Utilization and Review System (SURS) and Program Integrity Audits/Reviews appeals

SURS and Program Integrity Audits/Reviews appeals are made to the State Medicaid Director.

(1) If a provider disagrees with a decision of the Surveillance, Utilization and Review System Unit (SURS) or Program Integrity Audit/Review which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision to the State Medicaid Director.

(2) The appeal from the SURS or Program Integrity Audit/Review decision will be commenced by the receipt of a letter from the appellant provider. The letter must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The letter should explain in detail, the factual and/or legal basis for disagreement with the allegedly erroneous decision. The letter will also include all relevant exhibits the provider believes necessary to decide the appeal.

(3) Upon the receipt of the appeal by the docket clerk, the matter will be docketed for the next meeting of the MAC. Any appeal received less than four weeks before a scheduled MAC meeting will be set for the following MAC meeting.

(4) The appeal will be forwarded to the SURS unit or Program Integrity Audit/Review unit by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case. A subcommittee of the MAC will be formed and render a recommendation to the State Medicaid Director.

(5) At the discretion of the MAC, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the Authority be present during their consideration of the appeal. Members of the Authority's Legal Division may be asked to answer legal questions regarding the appeal.

(6) The subcommittee will issue a recommendation regarding the appeal, in writing, within 30 days of the hearing. An exception to the 30 day rule will apply in cases where the subcommittee sets the case over until its next scheduled meeting in order to gather additional evidence. The written recommendation will

list the members of the subcommittee who participated in the decision. In cases where an appeal must be continued, the subcommittee will issue a letter within 30 days of the initial hearing to inform the appellant of the continuance.

(7) The recommendation, after being formalized, will be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director will issue a decision regarding the appeal within 60 days of the docket clerk's receipt of the recommendation from the MAC. The decision will be issued to the appellant or his/her authorized agent.

(8) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the CEO under OAC 317:2-1-13.

317:2-1-8. Nursing home provider contract appeals

This Section explains the appeal process to be accorded all nursing home providers whose contracts are terminated, denied or non-renewed. No procedure is afforded a nursing facility whose contract is limited in any other fashion.

(1) If a nursing home provider's contract is terminated, non-renewed or denied prior to the action's effective date, the provider will be afforded an informal reconsideration in accordance with 42 C.F.R. 431.154.

(2) The notice of termination, non-renewal or, denial of contract will include the findings it was based upon. The letter will be sent by certified mail to the provider.

(3) The provider will have 20 days to respond to the notice. The response should outline the reasons why the Authority's decision to terminate, non-renew, or deny the contract is wrong. The response by the provider must include a detailed position addressing the findings set out in the Authority's letter. The provider may request an extension of the 20 day limit if "good cause" exists that prevents the provider from refuting the findings in 20 days. A finding of "good cause" is in OHCA's discretion.

(4) Based upon the provider's response, the Authority will affirm or deny the notice of non-renewal, termination or denial.

(5) If the Oklahoma Health Care Authority affirms the notice of termination, non-renewal, or denial or the provider files no timely response, the effective date will pass and upon affirmation of the notice, the process described in OAC 317:2-1-2(b), 317:2-1-2(c)(2) and 317:2-1-5(b) will apply.

(6) The hearing afforded the provider after the effective date will satisfy the requirements of 42 C.F.R. 431.153.

(7) If the facility is a skilled nursing facility, the facility will receive a notice as required by 42 C.F.R. 431.153(d)(1) and (2).

317:2-1-8. Nursing home provider contract appeals

This Section explains the appeal process to be accorded all nursing home providers whose contracts are terminated, denied or non-renewed. No procedure is afforded a nursing facility whose contract is limited in any other fashion.

(1) If a nursing home provider's contract is terminated, non-renewed or denied prior to the action's effective date, the provider will be afforded an informal reconsideration in accordance with 42 C.F.R. 431.154.

(2) The notice of termination, non-renewal or, denial of contract will include the findings it was based upon. The letter will be sent by certified mail to the provider.

(3) The provider will have 20 days to respond to the notice. The response should outline the reasons why the Authority's decision to terminate, non-renew, or deny the contract is wrong. The response by the provider must include a detailed position addressing the findings set out in the Authority's letter. The provider may request an extension of the 20 day limit if "good cause" exists that prevents the provider from refuting the findings in 20 days. A finding of "good cause" is in OHCA's discretion.

(4) Based upon the provider's response, the Authority will affirm or deny the notice of non-renewal, termination or denial.

(5) If the Oklahoma Health Care Authority affirms the notice of termination, non-renewal, or denial or the provider files no timely response, the effective date will pass and upon affirmation of the notice, the process described in OAC 317:2-1-2(b), 317:2-1-2(c)(2) and 317:2-1-5(b) will apply.

(6) The hearing afforded the provider after the effective date will satisfy the requirements of 42 C.F.R. 431.153.

(7) If the facility is a skilled nursing facility, the facility will receive a notice as required by 42 C.F.R. 431.153(d)(1) and (2).

317:2-1-10. Drug Rebate appeal process

The purpose of this Section is to afford a process to both the manufacturer and the state to administratively resolve drug rebate discrepancies. These rules anticipate discrepancies between the manufacturer and OHCA which would require the manufacturer to pay a higher rebate or a lower rebate. These regulations provide a mechanism for both informal dispute resolution of drug rebate discrepancies between the manufacturer and OHCA and a mechanism for appeals of drug rebate discrepancies between the manufacturer and OHCA.

(1) The process begins at the end of each calendar quarter when the Authority will mail a copy of the State's past quarter's utilization data to the manufacturer. Utilization data and a billing for rebates will be mailed to the manufacturer within 60 days after the end of each quarter. It is this data which dictates the application of the federal drug rebate formula.

(2) Within 30 days from the date utilization data is sent to the manufacturer, the manufacturer may edit state data and resolve data inconsistencies with the state. The manufacturer may utilize telephone conferences, letters and any other mechanism to resolve data inconsistencies in mutual agreement with the state.

(3) Within 30 days after the utilization data is mailed to the manufacturer, the manufacturer may:

(A) pay the same amount as billed by the state with the quarterly utilization date;

(B) pay an amount which differs from the amount billed by the state with the utilization data and send disputed data information;

(C) pay nothing and send no disputed data information;

(D) pay nothing and send disputed data information.

(4) In the event the state receives the rebate amount billed by the 30th day, the dispute ends.

(5) If after 30 days one of the following events occurs, the state will acknowledge the receipt of the correspondence and review the disputed data:

(A) the receipt of an amount lower than that billed to the manufacturer;

(B) the receipt of disputed data.

(6) In the event no disputed data is received and no payment is received, interest will be computed in accordance with the provisions of federal law found at 42 U.S.C. Section 1396b(d)(5) and will be compounded upon the amount billed from 38 days after the date utilization data is sent.

(7) In the event a lower amount than billed is paid or in the event disputed data is sent, and no money is received, interest will be computed in accordance with 42 U.S.C. Section 1396(d)(5) and will be computed from 38 days from the date utilization data is sent to the manufacturer.

(8) Within 70 days from the date utilization data is sent to the manufacturer, the state will make its final informal review of the disputed data. OHCA will mail a second notice to the manufacturer which will include:

(A) receipt of the rebate, if any;

(B) receipt of the dispute;

(C) a statement regarding the interest amount; and

(D) a statement regarding the appeal rights of the manufacturer with a copy of the appeal form.

(9) Within 90 days of the date utilization data is sent to the manufacturer or within 20 days of the date a second notice is mailed to the manufacturer, whichever is sooner, the state or the manufacturer may request a hearing to administratively resolve the matter.

(10) The administrative appeal of drug rebate discrepancies includes:

(A) The appeal process will begin by the filing of a form LD-2 by the manufacturer or OHCA.

(B) The process afforded the parties will be the process found at OAC 317:2-1-5(b). The process provided by OAC 317:2-1-2(b) and (c) will also apply to these hearings.

(C) With respect to the computation of interest, interest will continue to be computed from the 38 day based upon the policy contained in the informal dispute resolution rules above.

(D) The ALJ's decision will constitute the final administrative decision of the OHCA.

(E) If the decision of the ALJ affirms the decision of OHCA in whole or in part, payment from the manufacturer must be made within 30 days of the decision. If the decision of the ALJ reverses the decision of the OHCA, the OHCA will make such credit or action within 30 days of the decision of the ALJ.

(F) The nonpayment of the rebate by the manufacturer within 30 days after the ALJ's decision will be reported to the Centers for Medicare and Medicaid Services and may be the basis of an exclusion action by the OHCA.

317:2-1-11. Medicaid Drug Utilization Review Board (DUR) appeal process

This Section explains the appeal process, pursuant to 63 O.S. '5030.3(8) (Supp. 1999), accorded any part aggrieved by a decision of the OHCA Board or Administrator (CEO) concerning a proposed recommendation of the Medicaid Drug Utilization Review Board (DUR).

(1) The aggrieved party may appeal pursuant to OAC 317:2-1-2 et seq. OHCA Appeals).

(2) The Board finds that the prescription of Title 63 O.S. '5030.3(B) is somewhat contradictory with the functions of the DUR Board. More specifically, in most instances, the DUR Board suggests policies that must be rule made. Rules promulgated by the OHCA Board do not lend to an "individual proceeding notice" as contemplated by Article II of the Oklahoma Administrative Procedures Act, specifically, Title 75 O.S. '309. Thus, in instances where the OHCA Board promulgates rules as a result of policy recommendations by the DUR Board, this Board will consider a party aggrieved by these rules to have filed a Petition for Rulemaking under 75 O.S. '305. In making this interpretation of 63 O.S. '5030.1, the Board will not enforce the last sentence of 74 O.S. '305. In making this interpretation, the Board finds that it is taking two somewhat conflicting provisions, and combining them to effectuate the intent of the legislature - to provide a hearing to those aggrieved by recommendations by the DUR Board and accepted by the OHCA Board.

(3) In instances where the DUR Board makes a recommendation accepted by the Board against an individual provider [for example, a recommendation under 42 U.S.C. '1396a8(g)(3)(c)(iii)(IV)], OHCA will provide an individual proceeding under the Oklahoma Administrative Procedures Act.

(4) In any appeal under (1) and (2) of this subsection, the OHCA Board delegates the OHCA ALJ to preside over the above hearing and present the Board with proposed findings of fact and conclusions of law in accordance with Article II of the Administrative Procedures Act. The OHCA Board may accept the ALJ's written decision, reject it, or amend the recommendations.

(5) Appeals filed pursuant to (1) and (2) of this subsection, will be made within 20 days of the OHCA Board's acceptance of the recommendation by the DUR Board.

(6) After Proposed Findings of Fact and Conclusions of Law are presented to the OHCA Board, the Board will have a period of 120 days to issue a final administrative order.

(7) The Agency's Legal Services Division will construct a form called the LD-3, which will be used for parties to file an action under (1) and (2) of this subsection.

317:2-1-12. For Cause provider contract suspension/termination appeals process

This Section explains the appeals process for providers whose Medicaid contracts have been suspended/terminated by the OHCA for cause. Those providers whose contracts have been affected by other OHCA actions cannot request an appeal of those measures.

(1) Procedure for suspending/terminating provider's contract.

(A) Notice of proposed suspension or termination. The OHCA will provide notice to the medical services provider of the proposed suspension or termination of provider contract. The written notice of suspension/termination will state:

(i) the reasons for the proposed suspension/termination;

(ii) the date upon which the suspension/termination will be effective; and

(iii) a statement that the medical services provider has a right to review prior to the suspension/termination of the provider's contract (refer to subparagraph (B) of this paragraph).

(B) Right to review prior to suspension/termination of provider contract. Before the medical services provider's contract is suspended or terminated, the OHCA will give the medical services provider the opportunity to submit documents and written arguments against the suspension/termination of the provider's contract.

(C) Notice of suspension or termination.

(i) After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-suspension or termination hearing.

(ii) After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-sanction hearing. Should the OHCA decide not to suspend or terminate the provider's contract, the medical services provider will be notified of the reasons for the decision.

(iii) Should the OHCA make a decision to suspend or terminate the medical services provider's contract, the OHCA will send a notice stating:

(I) the reasons for the decision;

(II) the effective date of the suspension or termination of the contract;

(III) the medical services provider's right to request a post-suspension or termination hearing;

(IV) the earliest date in which the agency will accept a request for reinstatement; and

(V) the requirements and procedures for reinstatement.

(2) **Post-suspension/termination hearing.** After the effective date of the suspension or termination of the provider's contract, the medical services provider is entitled to receive a post-suspension or termination hearing. The hearing committee for the OHCA will be comprised of three members of the OHCA and two other members as appointed. The representative who investigated the case will not be a representative if an investigation was initiated or completed.

(A) After the provider's request for the post-suspension/termination hearing is made, a hearing date will be established. A certified letter will be sent to the provider giving notification of the hearing date and naming the contact person. The contact person will answer procedural questions about the hearing.

(B) Ten days prior to the hearing, the medical services provider will submit a brief written statement detailing the evidence which will be presented by the provider at the hearing. Such statement must detail the facts which will be refuted by the provider. The purpose of the hearing will be limited to issues raised in the letter of suspension or termination as the cause of suspending or terminating the provider contract.

(C) The provider may be represented by an authorized representative, with documentation to that effect, at the informal hearing and/or the provider may present testimony himself or herself and have witnesses present.

(D) At the conclusion of the hearing, a decision will be made by the Hearing Committee. The provider will be notified in writing of the decision within 20 days of the final day of the hearing. The decision letter will constitute the agency's final decision regarding the matter.

317:2-1-13. Appeal to the Chief Executive Officer

An appeal to the Chief Executive Officer (CEO) of the Oklahoma Health Care Authority includes:

(1) Within 20 days of decisions made pursuant to provider or SURS/Program Integrity Audits/Reviews appeals found at this Chapter, either party may appeal a decision to the CEO of the Authority. Such appeal will be commenced by a letter or fax received by the CEO within 20 days of the receipt of the prior decision made by the ALJ or Medicaid Director. The appeal will concisely and fully explain the reasons for the request. No new evidence may be presented to the CEO. Evidence presented must be confined to the records below.

(2) Appeals to the CEO under recipient proceedings will be commenced by a letter received no later than 10 days of the receipt of the decision by the ALJ. Should the appellant request a transcription to prosecute its appeal to the CEO, the appellant will be required to execute a waiver relieving the OHCA from completing its fair process hearing within 90 days.

(3) For provider and SURS/Program Integrity Audits/Reviews proceedings, the CEO will have 90 days from receipt of the appeal to render a written decision.

(4) For recipient proceedings, the CEO will have 30 days from receipt of the appeal to render a written decision.

(5) The only appeal for proposed administrative sanctions is before the ALJ and the ALJ decision is not appealable to the CEO.

317:35-3-2. Medicaid transportation and subsistence

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible Medicaid recipients who are not otherwise covered through their Managed Care Plan and who are in need of Medicaid medical services.

Reimbursement for transportation costs must be prior authorized by the local Department of Human Services' (OKDHS) county director. Transportation costs must be for a medically necessary examination or treatment and only when transportation is not otherwise available. Payment through Medicaid may be made for transportation by private vehicle, bus, taxi, ambulance or airplane. Payment is made for a private vehicle at the Medicaid fee schedule rate and for public carrier at the public carrier rate. Individuals transporting more than one authorized recipient, from and to one destination and back, at the same time are reimbursed for only one trip. When transporting more than one authorized recipient, from and to and back to different locations, at the same time, reimbursement is made for one round trip. Beginning June 1, 1999, the Oklahoma Health Care Authority (OHCA) will begin a pilot transportation broker project with the Metropolitan Tulsa Transit Authority (MTTA) known as SoonerRide. SoonerRide will exclude individuals who are enrolled in a Managed Care Organization (MCO) through OHCA, those individuals who are categorized as institutionalized, and those individuals who are categorized as Qualified Medicare Beneficiaries Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB), and Qualifying Individuals-1. Clients seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which will be answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the client is required to notify SoonerRide at least 72 hours prior to the appointment. The client will be asked to furnish the SoonerRide reservation center the case number, home address, the time and date of the medical appointment, the address of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide will make arrangements for the most appropriate, least costly transportation. SoonerRide will verify appointments when appropriate. The SoonerRide contractor will be responsible for recruiting providers in each county and ensuring that all transportation providers meet all appropriate regulations for the provision of public transportation. Provider qualifications will include, but is not limited to, verification of liability insurance and drug testing. All non-emergency transportation will be

arranged by SoonerRide. If the client disagrees with the transportation arranged or denied by SoonerRide, an appeal should be filed with OHCA within 48 hours of the notification. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the client. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision will be final. As provider networks are developed, SoonerRide will be expanded to include additional counties. Before a county is phased into SoonerRide, county officials and clients will be notified. A public meeting will be held prior to inclusion of each new county.

(1) Authorization for transportation by private vehicle.

(A) Reimbursement for transportation by a private vehicle (privately owned, leased or rented) may be made directly to the client or to another person providing the private transportation for the client. Authorization cannot be made to a OKDHS or OHCA employee or the spouse of a OKDHS or OHCA employee, unless he/she is a certified volunteer, or any employee of another county, state or federal agency who is providing the transportation as a part of the regular duties within that agency. Private transportation is authorized at the Medicaid fee schedule rate from and to the transporter's point of origin. Claim for payment is filed on a travel reimbursement form, after it has been documented that the individual kept the appointment(s) for the medical services. Transportation by a private vehicle may be authorized when the recipient:

(i) lives in a rural area where needed Medicaid medical examination or treatment is not available and the recipient must travel outside his/her local community to receive the needed medical services.

(ii) receives Medicaid medical services within his/her own community, and it has been documented that the transportation cannot be made available through the individual's own efforts or through community volunteer resources.

(B) The distances for which reimbursement is claimed may not exceed the distances set forth in the latest Transportation Commission road map. Travel claimed between points not shown

on the official map shall be based on actual odometer readings. Vicinity travel is entered on travel claims as a separate item from road map mileage, for city and rural traveling within a small area, and is computed using mileage on the basis of actual odometer readings.

(C) Travel is reimbursed on the basis of the actual number of miles traveled from the transporter's point of origin to the first official call, subsequent official calls, and return to the point of origin. Recipients or transporters returning to a destination other than the original starting point (with local OKDHS County Director approval) must provide a brief explanation on the travel reimbursement form.

(D) Reimbursement for out-of-state transportation (not to exceed 100 map miles) that is medically necessary and would not require reimbursement for per diem may be authorized when the transportation is deemed in the best interest of the recipient and the OHCA.

(2) Reimbursement for public transportation.

(A) **Authorization for transportation by bus.** Transportation by bus is authorized when it is necessary for an eligible individual to receive treatment in a medical facility. (If the services of an escort are necessary, see (6) of this Section).

(B) **Authorization for transportation by taxi.** Taxi service may be authorized only when transportation cannot be arranged through the individual's own efforts or through community resources. When taxi service is necessary to transport recipients to and from their home to the medical provider or to the nearest point of common carrier access or a common carrier to the medical provider, reimbursement is paid on the basis of actual expenses. A memo giving a detailed explanation of why the taxi service had to be used must be attached to the travel reimbursement form. Taxicab charges must be itemized on the travel reimbursement form and are reimbursed only upon justification as to the necessity of their use.

(3) Transportation by ambulance (ground, air ambulance or helicopter). Transportation by ambulance is compensable for

individuals eligible for Medicaid benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility (a physician's office or clinic is not considered a medical facility) for medical care compensable under Medicaid.

(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA, Medical Authorization Unit, who will make the necessary flight arrangements.

(5) **Subsistence (sleeping accommodations and meals).** An individual who is eligible for transportation to or from a medical facility to obtain medical services may receive assistance with the necessary expenses of lodging and meals from Medicaid funds. If the individual does not have the funds for the necessary subsistence, authorization is made by the local office on Room and Board Order form. The individual may choose to pay for the lodging and meals and be reimbursed by filing a travel reimbursement form. Any subsistence expense claimed on the travel reimbursement form must be documented with receipts, and reimbursement cannot exceed state per diem amounts. Payment for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(6) **Escort assistance required.** Payment for transportation and subsistence of one escort may be authorized if the service is required. Only one escort may be authorized. It is the responsibility of the Oklahoma Department of Human Services' social worker to determine this necessity. The decision should be based on the following circumstances:

(A) when the individual's health does not permit traveling alone; and

(B) when the individual seeking medical services is a minor child.

317:35-15-8.1. Agency Personal Care contractors; billing, and problem resolution

The Administrative Agent (AA) certifies qualified agencies and facilitates the execution of contracts on behalf of OHCA with qualified agencies for provision of Personal Care services. At contract renewal, the AA re-evaluates provider qualifications and facilitates execution of renewal contracts on behalf of the OHCA. OHCA will check the list of providers that have been barred from Medicare/Medicaid participation to ensure that the provider agency is not listed.

(1) **Payment for Personal Care.** Payment for Personal Care is generally made for care in the client's own home. A rented apartment, room or shelter shared with others is considered "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., does not constitute a suitable substitute home. Personal Care may not be approved if the client lives in the PCA's home except with the interdisciplinary team's written approval. #1 With OKDHS area nurse approval, or for ADvantage waiver clients, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the client in achieving vocational goals identified on the service plan. #2

(A) **Use of agency contractors for Personal Care.** To provide Personal Care services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by OKDHS or the Administrative Agent (AA), and possess a current Medicaid contract. #3

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

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

efficient manner to meet the needs of all eligible persons in the household.

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

(2) **Problem resolution.** If the client is dissatisfied with the agency or the assigned PCA, the client contacts the LTC nurse for problem resolution. If the situation cannot be resolved, the client has the right to appeal to the OHCA. (Refer to OAC 317:2-1-2). For clients receiving ADvantage services, their case manager should be contacted for the problem resolution. If the problem remains unresolved, the contact may be made with the Consumer Inquiry System (CIS) at the Long Term Care Authority.

INSTRUCTIONS TO STAFF

1. The LTC nurse, with input from the DHS social worker, submits a written request for an exception to the rule for the client receiving Personal Care while living in the PCA's home. Documentation included with the exception request shall include the name and case number of the client, the name and address of the potential PCA, the client's diagnosis, physical condition and care needs, and the reason for the request.
2. The LTC nurse or Administrative Agent (AA) nurse submits a written request to the area nurse for an exception to the rule restricting provision of Personal Care to the home setting. Documentation included with the exception request shall include the name and case number of the client, the client's vocational goal(s) and goal justification, the name of the potential PC agency, the client's diagnosis and care needs in the vocational setting, the number of units of care requested per week in the vocational setting, and the vocational setting name and address.
3. Clients will be provided a list of agencies from which to choose. If the client is unable to make a choice, the LTC nurse or the Administrative Agent makes the selection for the client

using a rotating system.

317:35-19-16. PASRR appeals process

(a) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Forms for requesting a fair hearing (OAC 340:2, Appendix G), as well as assistance in completing the forms, can be obtained at the local county office. Any request for a hearing must be made no later than 20 days following the date of written notice. There is no distinction between the Medicaid and non-Medicaid patient; therefore, all individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(b) When the individual is found to experience MR or MI through the Level II screen, the PASRR determination made by the MR/MI authorities cannot be countermanded by the state Medicaid agency, either in the claims process or through other utilization control/review processes, or by the state survey and certification agency. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the MR/MI authorities.

317:45-1-2. Program limitations

(a) The O-EPIC program is contingent upon sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(b) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the Program.

(c) The Program is funded through a portion of monthly proceeds from the Tobacco Tax, House Bill 2660, that are collected and dispersed through the HEEIA revolving fund.

(d) The Program is limited in scope such that budgetary limits are not exceeded. If at any time it becomes apparent there is risk the budgetary limits may be exceeded, OHCA must take action to ensure the O-EPIC program continues to operate within its fiscal capacity.

(1) O-EPIC may limit eligibility based on:

(A) the federally-approved capacity of the O-EPIC services for the Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver; and

(B) Tobacco Tax collections.

(2) The O-EPIC program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list of employers.

(A) Employers, not previously enrolled and participating in the program, submitting new applications for the O-EPIC program are placed on a waiting list. These applications are date and time stamped by region when received by the TPA. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability.

(B) The waiting list utilizes a "first in - first out" method of selecting eligible employers by region.

(C) When an employer group is determined eligible and moves from the waiting list to active participation, the employer must submit a new application. All eligible employees of that employer will have an opportunity to participate in O-EPIC during the employer's eligibility period.

(D) Only employers will be subject to the waiting list. (E) Enrolled employers who are currently participating in the O-EPIC program are not subject to the waiting list.

(i) If the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate in O-EPIC during the employer's current eligibility period.

(ii) If the employer has an employee who has a Qualifying Event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the Qualifying Event.

317:45-3-1. Carrier eligibility

Carriers must file a quarterly financial statement with the Oklahoma Insurance Department and submit requested information to OHCA for each health plan to be considered for qualification. Carriers must also provide the name, address, telephone number, and, if available, email address of a contact individual who is able to verify O-EPIC employer enrollment status in a Qualified Health Plan.

317:45-7-1. Employer application and eligibility requirements for O-EPIC

(a) In order for an employer to be eligible to participate in the O-EPIC program the employer must:

(1) have no more than a total of 25 employees on its payroll, including those working at the corporate level and within all subsidiaries.

(A) Subsidiaries are defined as:

(i) a company effectively controlled by another or associated with others under common ownership or control; or

(ii) two or more employers sharing common ownership, management, or control, all for the purpose of achieving a common business interest.

(B) The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) and that is in compliance with all requirements of the OESC. If the employer is exempt from filing an OES-3 form, in accordance with OHCA rules, this determination is based on appropriate supporting documentation, such as the W-2 Summary Wage and Tax form as required under OAC 365:10-5-156 to verify employee count;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering or intending to offer within 60 calendar days an O-EPIC Qualified Health Plan. The Qualified Health Plan coverage must begin on the first day of the month and continue through the last day of the month;

(4) offer Qualified Health Plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies;

(5) contribute a minimum 25 percent of the eligible employee monthly health plan premium;

(b) An employer who meets all requirements listed in subsection (a) of this Section must complete and submit an employer enrollment packet to the TPA.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) The employer must notify the TPA, within 5 working days from occurrence, of any O-EPIC employee's termination or resignation. Additionally, the employer must notify the TPA of new hires within 30 days of eligibility for the health plan.

317:45-7-2. Employer eligibility determination

Eligibility for employers is determined by the TPA using the eligibility requirements listed in OAC 317:45-7-1. An employer determined eligible for O-EPIC is approved for up to a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The eligibility period ends the last day of the 12th month or when coverage through a health plan requires renewal or an open enrollment period occurs. The TPA notifies the employer of the eligibility decision for employer and employees.

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit the current health plan invoice to the TPA via fax or mail.

317:45-9-1. Employee eligibility requirements

(a) Employee premium assistance applications are made with the TPA. Employees of an O-EPIC eligible employer must apply within 30 days from the date the employer is approved for O-EPIC or within 30 days from the date they are hired to work for a participating employer and are eligible for enrollment in the health plan. Employees may also apply during the employer's health plan open enrollment period.

(b) The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility. The eligibility determination is processed within 30 days from the date the application is received by the TPA. The employee is notified in writing of the eligibility decision.

(c) All O-EPIC eligible employees described in this Section are enrolled through their Employer Sponsored Health Plan (ESHP). Employees eligible for O-EPIC must:

(1) have a household income at or below 185% of the Federal Poverty Level;

(2) be US citizens or aliens as described in OAC 317:35-5-27;

(3) be Oklahoma residents;

(4) provide his/her social security number;

(5) be not currently enrolled in, or have applied for, Medicaid/Medicare;

(6) be employed with a qualified employer at a business location in Oklahoma;

(7) be age 19 through age 64;

(8) be eligible for enrollment in the employer's Qualified Health Plan;

(9) be working for employers (if multiple) who all meet the eligible employer guidelines;

(10) select one of the Qualified Health Plans the employer is

offering; and

(11) make application within 30 days of the employer being approved or have a Qualifying Event.

(d) An employee's spouse is eligible for O-EPIC if:

(1) the employer's health plan includes coverage for spouses;

(2) the employee is eligible for O-EPIC;

(3) if employed, the spouse's employer meets O-EPIC employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and

(4) the spouse is enrolled in the same health plan as the employee.

(e) If an employee or spouse is eligible for multiple O-EPIC Qualified Health Plans, each may receive a subsidy under only one health plan.