
POLICY TRANSMITTAL NO. 08-38	DATE: JULY 24, 2008
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:35-18-1 through 35-18-11.

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

Programs of All-Inclusive Care for the Elderly (PACE) rules are issued to establish the requirements for the Cherokee Nation Pilot Program to provide home and community-based acute and long-term care services to eligible elderly clients who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community.

Agency rules are revised to allow for involuntary disenrollment of PACE program participants based upon certain actions of the participant's caregiver or guardian.

Original signed on 7-22-08

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WF # 08-M (NAP)

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 an "OKDHS" number, such as personnel policy at OKDHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates OKDHS 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, OKDHS 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, OKDHS: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 405-521-4326.

<u>REMOVE</u>	<u>INSERT</u>
-----	317:35-18-1, 1 page only, issued 7-1-06
-----	317:35-18-2, 1 page only, issued 7-1-06
-----	317:35-18-3, 1 page only, issued 7-1-06
-----	317:35-18-4, 1 page only, issued 7-1-06
-----	317:35-18-5, pages 1-2, issued 7-1-06
-----	317:35-18-6, pages 1-4, issued 7-1-06
-----	317:35-18-7, 1 page only, issued 7-1-06
-----	317:35-18-8, 1 page only, issued 7-1-06
-----	317:35-18-9, 1 page only, issued 7-1-06
317:35-18-10	317:35-18-10, pages 1-2, revised 7-1-08
-----	317:35-18-11, 1 page only, issued 7-1-06

317:35-18-1. Programs of All-Inclusive Care for the Elderly (PACE)

This chapter establishes the requirements for the Cherokee Nation Pilot Program to provide services to eligible elderly clients through the Oklahoma Health Care Authority's Programs of All-Inclusive Care for the Elderly (PACE).

317:35-18-2. Introduction

(a) Programs of All-Inclusive Care for the Elderly (PACE) provide home and community-based acute and long-term care services to eligible individuals who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community. PACE is optional in a State Medicaid program. PACE is jointly funded and administered by the Centers for Medicare and Medicaid Services and the state of Oklahoma. The PACE provider receives a monthly capitation payment and is at full risk for the delivery of all medically necessary services for the recipient. For eligible individuals who elect to participate in the PACE program, the OHCA will make capitation payments for individuals who are only eligible for Medicaid or who are dually eligible for Medicaid and Medicare. OHCA will contract with the Cherokee Nation for a PACE pilot program in the geographic areas as specified and approved in the Cherokee Nation PACE application. The Cherokee Nation PACE pilot program will provide medically necessary services to both American Indian/Alaska Native (AI/AN) and non-Indian Medicaid eligible recipients.

(b) Rules applicable to the operation of the PACE program are contained in 42 Code of Federal Regulations (CFR), Part 460. These regulations, as currently written or amended in the future, are incorporated by reference as the rule base for operating the PACE program in Oklahoma.

317:35-18-3. Definitions

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

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card;

(2) **"Capitation"** means the per member per month (pmpm) amount that the Oklahoma Health Care Authority pays to the PACE provider.

(3) **"Interdisciplinary Team (IDT)"** means the team of persons who interact and collaborate to assess PACE clients and plan for their care as set forth in 42 CFR 460:102. The IDT may also include the PACE client's personal representative or advocate.

(4) **"Participant"** means an individual enrolled in a PACE program.

(5) **"Program agreement"** means the three-party agreement between the PACE provider, CMS, and OHCA.

(6) **"Provider"** means the non-profit entity established by the Cherokee Nation that delivers required PACE services under an agreement with OHCA and CMS.

(7) **"Service area"** means the geographic area served by the provider agency, according to the program agreement.

(8) **"State Administering Agency (SAA)"** means the Oklahoma Health Care Authority.

317:35-18-4. Provider regulations

(a) The provider must comply with provisions of this Subchapter, and the regulations in 42 CFR, Part 460.

(b) The provider agency must be licensed by the State of Oklahoma as an adult day care center.

(c) The provider must meet all applicable local, state, and federal regulations.

(d) The provider must maintain an inquiry log of all individuals requesting Programs of All-Inclusive Care for the Elderly (PACE) services. This log will be available to the OHCA at all times. The log must include:

(1) type of contact;

(2) date of contact;

(3) name and phone number of the individual requesting services;

(4) name and address of the potential client; and

(5) date of enrollment, or reason for denial if the individual is not enrolled.

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in PACE, the applicant must:

(1) meet categorical relationship to disability (reference OAC 317:35-5-4);

(2) meet medical and financial criteria for the ADvantage program (reference OAC 317:35-17-2, 317:35-17-10, and 317:35-17-11);

(3) be age 55 years or older;

(4) live in a PACE service area;

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

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

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

(C) maintain supporting documentation for the denial and notify CMS and OHCA of the denial and make the supporting documentation available for review; and

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

(b) To be eligible for Medicaid capitated payments, the participant must:

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

(2) be eligible for Medicaid State Plan services;

(3) be eligible for the Medicaid ADvantage program per OAC 317:35-17-3 and 317:35-17-5.

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

317:35-18-6. Program benefits

(a) A provider agency must provide a participant all the services listed in 42 CFR 460.92 that are approved by the IDT. The PACE benefit package for all participants, regardless of the source of payment, must include but is not limited to the following:

- (1) All Medicaid-covered services, as specified in the State's approved Medicaid plan.
- (2) Interdisciplinary assessment and treatment planning.
- (3) Primary care, including physician and nursing services.
- (4) Social work services.
- (5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services.
- (6) Personal care and supportive services.
- (7) Nutritional counseling.
- (8) Recreational therapy.
- (9) Transportation.
- (10) Meals.
- (11) Medical specialty services including, but not limited to the following:
 - (A) Anesthesiology.
 - (B) Audiology.
 - (C) Cardiology.
 - (D) Dentistry.
 - (E) Dermatology.
 - (F) Gastroenterology.

- (G) Gynecology.
 - (H) Internal medicine.
 - (I) Nephrology.
 - (J) Neurosurgery.
 - (K) Oncology.
 - (L) Ophthalmology.
 - (M) Oral surgery.
 - (N) Orthopedic surgery.
 - (O) Otorhinolaryngology.
 - (P) Plastic surgery.
 - (Q) Pharmacy consulting services.
 - (R) Podiatry.
 - (S) Psychiatry.
 - (T) Pulmonary disease.
 - (U) Radiology.
 - (V) Rheumatology.
 - (W) General surgery.
 - (X) Thoracic and vascular surgery.
 - (Y) Urology.
- (12) Laboratory tests, x-rays and other diagnostic procedures.
- (13) Drugs and biologicals.

(14) Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items.

(15) Acute inpatient care, including the following:

(A) Ambulance.

(B) Emergency room care and treatment room services.

(C) Semi-private room and board.

(D) General medical and nursing services.

(E) Medical surgical/intensive care/coronary care unit.

(F) Laboratory tests, x-rays and other diagnostic procedures.

(G) Drugs and biologicals.

(H) Blood and blood derivatives.

(I) Surgical care, including the use of anesthesia.

(J) Use of oxygen.

(K) Physical, occupational, respiratory therapies, and speech-language pathology services.

(L) Social services.

(16) Nursing facility care including:

(A) Semi-private room and board;

(B) Physician and skilled nursing services;

(C) Custodial care;

(D) Personal care and assistance;

(E) Drugs and biologicals;

(F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;

(G) Social services; and

(H) Medical supplies and appliances.

(17) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(b) The following services are excluded from coverage under PACE:

(1) Any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service.

(2) In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care).

(3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

(4) Experimental medical, surgical, or other health procedures.

(5) Services furnished outside of the United States, except as follows:

(A) in accordance with 42 CFR 424.122 through 42 CFR 424.124, and

(B) as permitted under the State's approved Medicaid plan.

317:35-18-7. Appeals process

(a) Internal appeals

(1) Any client who is denied program services is entitled to an appeal through the provider.

(2) If the client also chooses to file an external appeal, the provider must assist the client in filing an external appeal.

(b) External appeals may be filed by any client covered by:

(1) Medicaid through the OHCA legal division.

(2) Medicare but not Medicaid through the Centers for Medicare and Medicaid Services hearing process.

317:35-18-8. Enrollment

(a) The provider determines whether the applicant meets PACE enrollment requirements.

(b) The enrollment effective date is the first day of the month after the provider receives the signed enrollment form.

(c) Enrollment continues until the participant's death, regardless of changes in health status, unless either of the following actions occur:

(1) The participant voluntarily disenrolls.

(2) The participant is involuntarily disenrolled.

317:35-18-9. Continuation of enrollment

(a) At least annually, OHCA must reevaluate whether a participant needs the level of care for nursing facility services.

(b) At least annually, OKDHS will reevaluate the participant's financial eligibility for Medicaid.

(c) If the individual meets the state's medical eligibility criteria and the individual has an irreversible or progressive diagnosis or a terminal illness that could reasonable be expected to result in death in the next six months, and OHCA determines that there is no reasonable expectation of improvement or significant change in the condition because of severity of a chronic condition or the degree of impairment of functional capacity, OHCA will permanently waive the annual recertification requirement and the client may be deemed to be continually eligible for PACE. The assessment form must have sufficient documentation to substantiate the participant's prognosis and functional capacity.

(d) If OHCA determines that a PACE participant no longer meets the medical criteria for nursing facility level of care, the participant may be deemed to continue to be eligible for PACE until the next annual reassessment, if, in the absence of PACE services, it is reasonable to expect that the client would meet the nursing facility level of care criteria within the next six months.

(e) Participant enrollment continues when OHCA in consultation with the PACE organization, makes a determination of continued eligibility based on a review of the participant's medical record and plan of care.

317:35-18-10. Disenrollment (voluntary and involuntary)

(a) The member may voluntarily disenroll from PACE at any time without cause but the effective date of disenrollment must be the last day of the month.

(b) A participant may be involuntarily disenrolled for any of the following reasons:

(1) The participant/caregiver or guardian fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.

(2) The participant/caregiver or guardian engages in disruptive or threatening behavior, as described in subsection (c) of this section.

(3) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The participant is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible.

(5) The PACE program agreement with CMS and the State administering agency is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

(c) A participant may be involuntarily disenrolled for disruptive or threatening behavior. For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:

(1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or

(2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

(d) If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:

(1) The reasons for proposing to disenroll the participant.

(2) All efforts to remedy the situation.

(e) A participant may be disenrolled involuntarily for noncompliant behavior.

(1) PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical

condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others.

(2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

(f) Before an involuntary disenrollment is effective, the State administering agency must review it and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

317:35-18-11. Data collection and reporting

The PACE provider must:

- (1) collect and enter data into the DATA PACE system.
- (2) generate and maintain monthly reports from the DATA PACE system.
- (3) make the reports available to the OHCA.
- (4) comply with all data requests as specified by the OHCA within 30 days of such requests.