MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
September 15, 2011
1:00 p.m. – Ponca Conference Room
2401 NW 23rd St., Suite 1A
Oklahoma City, OK 73107

I. Welcome, Roll Call, and Public Comment Instructions

II. Approval of minutes of the May 19, 2011 Medical Advisory Committee Meeting

III. MAC Member Comments/Discussion
MAC Workgroup Update, Terrie Fritz and Tanya Case

IV. Financial Report, End of Year: Gloria Hudson-Hinkle, Director of General Accounting
   A. June Financial Summary
   B. June Financial Detail Report

V. Board Retreat Update – Buffy Heater, Planning & Development Manager

VI. DUR Update – College of Pharmacy

V. Budget Update 2012: Juarez McCann, Chief Budget Officer

VI. SoonerCare Operations Update: Debbie Spaeth, Behavioral Health Services Director
   A. SoonerCare Programs Report
   B. Behavioral Health Update

VII. Action Items: Traylor Rains, Policy Development Coordinator

OHCA Initiated

11-16 Cost Sharing for Pregnant Women – SoonerCare cost-sharing rules are revised to clarify OHCA's current policy that pregnancy-related services are exempt from cost-sharing requirements.
Budget Impact - Budget Neutral

11-17 Prescription Exemption for DME Repairs – SoonerCare provider rules are amended to exempt durable medical equipment repairs with a cost per item of less than $250.00 from the prescription requirement.
Budget Impact – Budget Neutral

11-18 Supplemental Hospital Offset Payment Program (SHOPP) – OHCA is authorized by 63 Okla. Stat. §§ 3241.1 through 3241.6 to implement the Supplemental Hospital Offset Payment Program (SHOPP). OHCA is required by the SHOPP Act to assess in-state hospitals an assessment fee of

DRAFT

2.5%. Funds derived from the assessment are used to garner federal matching funds to supplemental Medicaid payment and pay participating hospitals a quarterly access payment.
Budget Impact: The assessment is expected to generate approximately $151 million in state dollars, $30 million of which is allocated to the Medical Payments Cash Management Improvement Act Program Disbursing Fund and used to maintain SoonerCare provider reimbursement rates. After garnering federal matching dollars, $336 million will be available to make supplemental payments to participating hospitals in the state of Oklahoma and approximately $83 million will be available to maintain SoonerCare provider payments.

OKDHS Initiated

11-11 ADvantage Waiver Rules - OHCA rules for the ADvantage Waiver are revised to remove Respiratory Therapy as an allowable service within the waiver and remove Hospice when the member is in a nursing facility receiving ADvantage Facility Based Extended Respite. Both services are removed due to lack of utilization. Additionally, rules are revised to remove language allowing for reimbursement to providers of case management transition services when the member fails to transition into the ADvantage waiver program. The revisions are necessary to align OHCA policy with revised operational procedures as approved by the Centers for Medicare and Medicaid Services.
Budget Impact – The Oklahoma Department of Human Services operates the ADvantage waiver and will benefit from the proposed rule change through realization of lower operational costs. An estimated savings of $15,000 annually will be realized through implementation of the rule change.

VIII. New Business

IX. Adjourn

Next Meeting: Thursday, November 16, 2011

DRAFT

MEDICAL ADVISORY COMMITTEE MEETING
Draft Meeting Minutes
May 19, 2011

Members attending: Dr. Aulgur, Ms. Bellah, Ms. Case, Dr. Crawford, Ms Patti Davis for Craig Jones, Ms. Karen Bradford for Ms. Sherry Davis, Ms. Patty Holden for Mr. Goforth, Dr. Grogg, Ms. Thayer for Mr. Howard Hendrick, Ms. Holliman-James, Dr. Kasulis, Mr. Duehning for Mr. Machtolff, Dr. McNeil, Dr. Post, Dr. Rhoades, Dr. Rhynes, Mr. Roye, Dr. Simon, Ms. Slatton-Hodges for Ms. White, Dr. Wells, Dr. Woodward, Dr. Wright

Members absent: Ms. Bates, Dr. Bourdeau, Mr. Brose, Dr. Cavallaro, Dr. Ogle, Mr. Tallent, Mr. Unruh

I. Welcome, Roll Call, and Public Comment Instructions

Dr. Crawford welcomed the committee members and called the meeting to order. Roll call established the presence of a quorum. There were no requests for public comment.

II. Approval of minutes of the March 9, 2011 Medical Advisory Committee Meeting

Dr. Post made the motion to approve the minutes as presented. Dr. Rhynes seconded. Motion carried.

III. MAC Member Comments/Discussion

Ms Case mentioned the Oklahoma Temporary High Risk Pool, part of the Affordable Care Act signed by the president in March. Oklahoma started the program in September last year. It is an insurance plan specifically for people who have not had insurance for the past six months, have a pre-existing condition, and cannot get insurance on the commercial market. It is not an entitlement program, members must pay their own premiums, but the premiums are priced at 100% of the commercial market. They are not rated up. These are the premiums by a "well" person. The state capacity is 900 people, there are 330 enrolled currently. There was a $60 million allocation, we can tell sick people are coming into the plan.

IV. Legislative Update: Nico Gomez, Deputy CEO

Please refer to the handout for an update. Session closes Friday, May 20th. The Senate is discussing the Affordable Care Act. HJR1064 received hearing. The Rule centers around the agency's ability to have individual contracts with licensed behavioral health providers This was an access issue for us, and the discussion to disapprove the resolution was an emotional one. The House Rules Committee voted 7-5 to disapprove the resolution. It's a double-negative. They disapproved the Resolution that disapproved the Rule, so the Rule still stands.

Mr. Gomez suggested tipping our hats to Sen. Jolley, Reps. Cox, Sen. Myers, Speaker Steele, Governor Fallin, the Office of State Finance and the Secretary of State. We started at $993 million, as the state share to match with federal Medicaid funding. The budget agreement, reduced our base by 1% to $983 million. We need $1 billion, $55 million in order to run the same programs that we're running today, at the same rates and same coverage level. HB1381, Supplemental Hospital Offset Payment Program (SHOPP bill), which has been at least six years in the making was introduced. In that bill was revenue to support hospital rates, but also some revenue for the agency's budget, ($30 million). That amount added to the $983 M shrinks the gap we need to maintain the program next year. We have some carryover that will further shrink that gap by at least half. We are thankful

DRAFT

to the Legislator and for the SHOPP bill. At the June meeting, the Board was able to consider a budget that is short dollar wise, but close enough that we should be able to manage. We will have more details by June. Our priority is to protect provider rates, and we will consider other options as needed..

SHOPP bill sunsets in 2014. Ms. Patti Davis commented that some legislatures were nervous about federal health care reform, and what that means regarding the Medicaid coverage provisions that kick in starting in 2014.There are a lot of unknowns. The thinking was to sunset the bill and re-visit the issue in 2014. If it's working as it should, then legislature will likely continue it. If it's not working as anticipated, then we repeal or make revisions. Dr. Crawford and Mr. Gomez congratulated all and stated the Oklahoma Hospital Association took the lead on this; HB1381 passed with Senate majority.

Dr. Crawford asked about the change in Rule making. Mr. Gomez replied that the rule making process did change. If a Rule has an economic impact, or deals with rates it must go through Permanent Rulemaking, the agencies cannot use Emergency Rulemaking.

Ms. Case asked about Licensed Professional Counselors (LPCs) rule that was discussed. Mr. Gomez replied we had an Emergency Rule last summer that allows us to have individual contracts with licensed behavioral health providers. A Rule was proposed that would have disapproved that practice. However we can still continue individually contracting with those providers.

V. Financial Report: Carrie Evans, Chief Financial Officer

Ms. Evans reviewed the financial transactions through the month of March 2011. For more detailed information see MAC information packet. There were no questions from members.

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

A. SoonerCare Programs Report
B. Member Services Highlights & SoonerRide

Mr. Rupe reviewed the SoonerCare Programs Report. Please refer to the handout for additional information.

Dr. McNeil mentioned a rural clinic, that was a Tier 3, and after review was downcoded to a Tier 2, and the provider said they had 1 year to wait to possibly be re-instated as Tier 3. They were hit hard by the difference in reimbursement, and Dr. McNeil asked if there is any recourse other than waiting for a year for re-review. Ms. Anthony explained that we have done extensive education, and auditing over several years visiting practices talking with doctors and their staff prior to implementation and even during the first year of implementation of the Medical Home, we had certain providers who were still unable to step up to expectations. We were advised by the Medical Advisory Task Force, our Legal dept. and QA Committee that we should give them one more year to meet the standards. During that year they keep their panel and fee-for-service payments, they just don't get their case management fee. We continue working with them again for a year, then at the end return to assess their compliance. The alternative was to drop them off the program all together.

Dr. Keenan said they don't even lose their case management fee for a full year, it depends on when the audit is done. They just don't get their fee for the rest of the year. Legal

DRAFT

notifies provider of this change and their need to meet the compliance standards that they told us they already had in place. We spent almost 3 years educating providers on Patient-Centered Medical Home and Tier requirements; failure to meet them usually indicates something else going on with a provider.

Mr. Pallotta explained that we have made payments to these providers from the first of the year based on their word, then we found their words were not their actions, they didn't do what they said they were doing.

Dr. Crawford asked what the appeal process is for Tiers if they ask for a review. Dr. Splinter responded they could ask for one. Although not contractually, a policy review. For clarification, providers are not waiting a year for a review, they get designated for a year, stay at that designation for a year, and a year later are re-reviewed. Ms. Anthony said in 2010 a few lost their Tier status. Upon review after a year's education process they all regained their priorTier status. Ms. Anthony will get with Dr. McNeil about the provider in question.

Mr. Rupe reviewed Member Services Highlights and SoonerRide.

The SoonerCare Helpline, in September, implemented online enrollment Useage went from 47,000 calls in April 2010, with over 95% of calls answered with 18 Customer Service Reps. and 2 managers, to 72,000 in April 2011. We increased staff to 32 representatives and 5 managers, and are able to answer slightly over 90% of the calls. Average call time was 2.5 minutes, now they are 4 minutes. We have a web-based service, which is a little slower, but a positive trade-off to the slowing down is that we are able to change the demographic information for our members and enter it in real time. In the past, we had to tell them to call DHS, to update their information, then DHS would that information back to us. On the SoonerCare Helpline, we are able to find the answer before the call ends. Ms. Case asked if it is taking longer because they call after getting stuck on the computer. Mr. Rupe explained it depends on what the questions are, and takes time to research.

There were no questions on SoonerRide or further questions.

VII. Mr. Gibson provided the MAC with an update on Team Day.

Team Day is held at the State Capitol every year during the Public Employees Recognition Week. The program presents the outcomes of successful projects by state entities, and allows them to be seen by the public, state agency officials, and members of the Legislature. Out of 55 teams, 13 represented OHCA.11 were considered for the Commendation, and 2 were presented as displays. 5 were awarded the Governor's Commendation; SoonerCare Choice, Oklahoma's Patient-Centered Medical Home; Online Enrollment, Practice Facilitation, Strengthening Primary Care for Chronic Illness in Oklahoma; Measuring Success, SoonerCare's Payment Accuracy Project; and Statewide Care Management Oversight Project. The specialty award, "Motivating Masses", went to Online Enrollment. The "Motivating Masses" designation is awarded to the team who demonstrates how they're were able to facilitate corroboration with many people across many agencies to reach the project goals. Team Day is the first week in May each year. Dr. Crawford commended all.

There were no questions.

DRAFT

VIII. Ms. Fritz addressed the MAC regarding membership, appointments, attendance and guidelines for operation.

The MAC's functions are being reviewed for clarity and process improvement. Functions for the MAC could be more not clearly delineated. Will plan to review and discuss this with MAC members and consider changes over the next few meetings. Some questions for consideration – How are we organized? Have we missed some groups? MAC is in statute, some groups are required, some are not. Recommendation is for a few MAC members to form a workgroup and meet with OHCA staff to review the guidelines.

Ms. Davis asked if the OHCA had a contact person for questions on Rules. We will get with Policy to include more information on contact names and numbers.

Dr. Crawford asked if this could be as formal as Bylaws. Mr. Pallotta responded we could do a non-APA Rule, binding only for MAC, not anyone else.

Dr. McNeil asked about the Medical Advisory Task Force (MAT – physician advisory group) and their discussion of Tiers, and how that it affects members. Where does the MAC fit into those considerations. Response was that groups such as the MAT are less formal advisory groups where ideas are generated; but do not necessarily result in any policy changes. Mr. Pallotta said these groups are subsets, per se, we utilize them for ideas. The more input, more ideas, the better.

Ms. Fritz explained the MAC's responsibility is to review the Rules.

Ms. Slatton-Hodges said attendance is crucial, someone needs to represent each member on the MAC if the member is unavailable.

Ms. Fritz suggested defining 1 or 2 alternates, 6-7 ad-hoc, at-large members. Dr. Crawford suggested providing members a background on MAC membership and attendance.

Ms Case, Ms. Davis, Dr. McNeil, Dr. Post, and Dr. Kasulis offered to volunteer to be on the workgroup.

Mr. Pallotta referred to a Rule regarding prescribers. Federal law now requires all providers referring or prescribing for SoonerCare members must be a SoonerCare provider (after March 23rd). As policy it makes sense under the Medical Home. The primary physician looks after the patient's medical needs. Members are getting prescriptions from non-SoonerCare physicians. When we call providers, they say ; Get lost, we are not contracted with you and don't need to talk to you. Dr. Crawford said some issues arise because providers are Locum Tenens, ER drs., specialists or resident drs. not contracted but under supervision of a SoonerCare contracted physician. Mr. Pallotta said the policy allows providers until July 1st to become contracted. A lot of members are out of state when they get non-SC contracted physician services. In those cases, we do a single case agreement.

Ms. Case asked if there will be communication to members on how to get reimbursed in these situations. Dr. Crawford said a patient got a letter that the resident is not contracted and the patient was worried. Looks like the letter went to patients and pharmacies, not physicians. Mr. Pallotta will check on this.

DRAFT

Dr. McNeil asked about hospital orders, prescriptions, and who the contracted provider is. Mr. Pallotta responded that is the hospital contract.

IX. Action Items: Joseph Fairbanks, Senior Policy Specialist

OHCA Initiated

11-07 PT/OT/ST Clarification — PT/OT/ST rules restrict individually-contracted provider services to children. Rules are amended to clarify in policy that there is no coverage for adults for services rendered by individually-contracted providers, however, therapy services are covered for adults in an outpatient hospital setting.
Budget Impact: Budget Neutral.

Federally Initiated

11-02 Tax Credit Exemption — The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 requires state Medicaid agencies to disregard federal tax refunds or advance payments with respect to refundable tax credits as income and as resources for purposes of determining eligibility. To bring Agency policy in compliance with this law, eligibility rules and income guidelines are revised to eliminate consideration of the Earned Income Tax Credit, which is the only refundable tax credit currently counted for eligibility purposes. **Budget Impact:** Budget Neutral

11-05 Insure Oklahoma—Native American Cost-Sharing — Insure Oklahoma cost-sharing rules are revised to comply with Federal law on Native American cost-sharing exemptions. Native American adults are exempt from Insure Oklahoma—Individual Plan co-pays or premiums when they receive services provided by Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) providers or through referral by contract health services. Native American children are exempt from cost-sharing regardless of whether they receive services provided by I/T/U providers or through referral by contract health services. **Budget Impact:** $189,422 total impact; $64,595 state impact

Dr. McNeil made the motion to approve Rules 11-07, 11-02, 11-05 as submitted. Ms. Bellah seconded.

Dr. Keenan provided a brief update on the member's mother, Ms. Saul, who addressed the last MAC meeting, regarding adult diapers for her daughter. Barbara Gibbons helped her in January and Melinda Jones assisted after the March MAC, and Ms. Saul was invited to be on the Member Advisory Task Force. Adult diapers are not covered.

X. New Business – Dr. Rhynes said he has a SoonerCare patient with keratoconus and traditionally glasses don't help, and they use contact lenses. SoonerCare allows the optometrist to treat and get paid. He said he has been getting denials for 90 days, and was told it went to Medical Review. Dr. Keenan asked that the information be sent to him, or to contact him. We will provide a follow-up to the MAC at the next meeting.

XI. Adjourn – 2:45 p.m.

DRAFT

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

September 8, 2011

Dear MAC Members,

At the last MAC meeting in May a sub-committee of the MAC was formed and given the task of developing written operational guidelines for consideration and possible adoption by the MAC full body. A draft has been developed and is attached for your review. The subcommittee consisted of Dan McNeill, Tanya Case, Heather Kasulis, Patti Davis, and Daniel Post. They met twice in person and provided very thoughtful discussion and suggestions that were the basis for the proposed guidelines. The goals of the work of the committee were to:

- Clarify the role of the MAC within the OHCA, SoonerCare and Insure Oklahoma
- Articulate the scope of issues and policies to be addressed by the MAC
- Establish expectations for attendance and participation of members
- Explain the duties and responsibilities of the appointed members
- Clarify the appointment processes
- Add/clarify the role of alternates and designees

Please make every effort to familiarize yourself with the suggested guidelines contained in the accompanying draft document before the meeting on September 15th. At the meeting there will be a full discussion of the proposed guidelines, opportunity for amendments and possible adoption of a set of agreed upon guidelines for operation.

If the proposed guidelines are adopted, every person currently seated on the MAC would still be able to serve on the MAC going forward. No current seats or represented organizations or constituencies would be dropped.

Terms of appointment would be for a three year term with one additional term for a total of six consecutive years of service. It is suggested that all current appointees would begin a new term upon adoption of these rules and official appointment under the applicable guidelines for their position or seat. In order to insure that three years from now all terms do not expire at once, it is suggested that each seat would serve an initial term of either one, two or three years, which will be determined through a random drawing process. After that initial one, two or three year term, all terms (new or reappointment) would be for three years.

Once again, the subcommittee members and OHCA staff that worked to develop the proposed guidelines hopes each of you will be able to review the attached draft document and attend the meeting next week for discussion and potential vote on adoption.

As always, thank you for your service and commitment to the important work of the MAC and the OHCA.

Sincerely,

J. Paul Keenan, M.D.
Chief Medical Officer
405-522-7176

Medical Advisory Committee
Oklahoma Health Care Authority
Proposed Guidelines for Operation
September 15, 2011

Background

The Medical Advisory Committee (MAC) of the Oklahoma Health Care Authority (OHCA) is a committee which is required by federal statute, as part of the regulation which governs the Title XIX Medicaid program. It is also addressed in Oklahoma State statute. As stated in 42CFR Ch. IV, 431.12, "the main purpose of the committee is to advise the agency about health and medical care services...the committee must have the opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program."

The MAC has been in existence since the inception of Oklahoma's Medicaid program. It was historically part of the DHS operational structure and has been part of the structure of the OHCA SoonerCare and Insure Oklahoma programs since the creation of OHCA in 1994.

The committee membership is representative of a wide range of health professionals, consumer stakeholders, professional associations, advocacy groups and state agencies which have an interest in the optimal functioning of the SoonerCare programs.

The MAC is advisory to the OHCA and serves to ensure that the policies and rules of the SoonerCare and Insure Oklahoma programs that are considered and acted on by the board of directors have had the benefit of input and review by the MAC membership in order to support optimal decision making.

It has been determined that the MAC does not fall under the Oklahoma Open Meetings Act, however, any interested parties are invited and encouraged to attend and every effort is made to inform a broad range of stakeholders of the agenda items and meeting dates and times. At the discretion of the Chair or presiding officer, anyone requesting to speak may be given an opportunity to do so.

Membership

The membership of the MAC is partially determined under state and federal guidelines which set out mandatory members. The federal and state statutes both allow for additional membership necessary to meet the needs of the programs. The CFR instructs that committee membership must include board certified physicians and other representatives of the health professions who are familiar with the medical needs of the low income population groups and with the resources required for their care. It also instructs that, "Members of consumer groups, including Medicaid recipients and consumer organizations be part of the committee membership." In addition, either the

state health agency or the state human services agency is to be part of the MAC. It is the desire of OHCA leadership to have active representation from a wide range of knowledgeable stakeholders who have a commitment to supporting and improving the program.

Duties of the MAC membership

The MAC conducts business through regularly scheduled meetings that are held on a bi-monthly basis. Regular meetings are scheduled in advance for the year. Additional meetings may be called if needed in order to fulfill the duties of the committee. Members may attend by phone and/or video conferencing as available.

The MAC reviews potential policy, state plan and waiver changes that have been developed by OHCA staff. Opportunity for review and discussion of an item will be at a minimum when the OHCA formally begins the exploration and discussion of a potential policy, state plan or waiver change and again for any policy, state plan or waiver change that will be presented to the Board of Directors for consideration/approval.

The MAC members will also be regularly updated on issues that are critical to the SoonerCare and Insure Oklahoma programs administration on a regular basis and will have opportunity for discussion and input.

Additionally, MAC members have the responsibility of keeping their organizations, agencies and constituencies informed and updated on the issues discussed and work conducted. Members are to develop strategies to ensure he or she represents the appointing organization or their constituency. OHCA staff will prepare written briefings on major topics, concerns or recommendations made by the MAC that can be used to facilitate the above informational exchange.

The OHCA has many other task forces, advisories and workgroups that function to obtain the knowledge, expertise and input needed to provide the optimal healthcare possible within the SoonerCare and Insure Oklahoma programs. These groups are usually focused on a particular area of health care (such as Behavioral Health, Perinatal Care, Child Health, Dental, etc.). The members of these advisories, task forces and workgroups provide ideas, suggestions and concerns for consideration and discussion and provide education back to their constituencies regarding the programs. MAC members are encouraged to attend and participate in any of the meetings of these groups. In addition, updates of the work of the various OHCA sponsored advisory groups and task forces will be regularly supplied to the MAC.

Appointments to the committee

The statute requires at least one physician from each of the six classes of physicians listed in state statute to be appointed to serve on the MAC. It also states they should be participating providers in the program. The following are the six physician classes:

- Doctor of Podiatry
- Doctor of Chiropractic
- Doctor of Dental Surgery or Doctor of Medical Dentistry
- Doctor of Allopathic Medicine
- Doctor of Optometry
- Doctor of Osteopathic Medicine

The statute further requires that the MAC have representation from consumers. It is required that MAC has members who represent the:

- Economically disadvantaged
- Children
- The elderly
- Persons with mental illness
- Persons with developmental disabilities and
- Persons with alcohol/substance abuse problems.

The CEO of the OHCA will solicit recommendations from the MAC members, OHCA task forces and advisory groups, staff and other OHCA stakeholders and will appoint a representative and an alternate to serve representing each of the six physician groups and each of the six consumer groups.

The Director of DHS is also a statutorily mandated member of the MAC. In addition, the OHCA invites the commissioners of the Oklahoma State Department of Health and the Oklahoma Department of Mental Health and Substance Abuse Services to serve. The directors/commissioners of these agencies may appoint a designee to serve in their stead and are asked in addition to name an alternate.

Additional organizations whose members provide health services through the SoonerCare and Insure Oklahoma programs are invited to participate on the MAC. The following organizations are asked to submit the name of a member to serve as the MAC member and another person to serve as the alternate.

- Oklahoma Hospital Association
- Oklahoma Nurses Association
- Academy of Physician Assistants
- Oklahoma Advanced Nurse Practitioner Association
- Oklahoma Psychological Association
- Oklahoma Pharmacists Association
- Oklahoma State Medical Association
- Oklahoma State Osteopathic Association
- National Association of Social Workers-Oklahoma Chapter
- Oklahoma Academy of Pediatrics
- Medical Equipment Suppliers' Association
- Oklahoma Speech Language and Hearing Association

- Oklahoma Association of Health Care Providers
- Oklahoma Long term Care Association
- Oklahoma Association for Home Care

The request for recommendations for appointment is made in writing by OHCA staff to the sitting president and/or executive director of the organization. S/he will return to OHCA in writing, the names and contact information of the members of their association or organization who been selected and who have agreed to serve.

Every MAC member or alternate who represents a profession or professional organization who is subject to Oklahoma licensing provisions must have a current unrestricted license in good standing and no current or historical disciplinary actions.

In order to insure a broad representative membership, OHCA leadership may appoint up to three additional MAC members who will serve as at-large appointments.

Terms of Service

Each member shall serve for a term of three years and may be reappointed for one additional three year term. If at the end of two consecutive terms, a suitable replacement cannot be identified, the current member may serve until a new person is identified and appointed. Members who are no longer able to serve are expected to submit their resignation in writing to the OHCA and if they are representing an organization or state agency, to also notify that entity.

DRAFT

Alternates

Each MAC member will have a regular alternate who is able to participate when the member is unable. Alternates will receive orientation and training and will receive all meeting materials and communications. They are encouraged to attend meetings, but may not vote unless the regular member is not present. Alternates will be named using the same process as the members.

Leadership

There is a Chair and a Vice Chair selected from among the MAC members who provide the meeting leadership and work with the OHCA staff to develop the agendas and oversee the functioning of the committee. The presiding Chair or Vice Chair will rely on Robert's Rules of Order to conduct the business of the MAC. The Chair and Vice Chair will serve two year terms, which may be repeated.

Attendance and Participation

A quorum of the MAC membership is required to conduct business. Members are asked to make every effort to attend all meetings of the MAC. However, in the event a regular member cannot attend, the identified alternate is encouraged to attend and is allowed to participate as a voting member. If there is a pattern of a member failing to attend

meetings and participating in the work of the MAC, then an identified OHCA staff will contact the member and their identified organization or agency (if applicable) to discuss whether a change in membership is needed. If the member has missed three or more consecutive meetings or has missed more than half of the meetings in the previous twelve months, the OHCA staff in consultation with the Chair and or Vice Chair may replace that member if it is a seat mandated in statute. If the member with a pattern of non-attendance is representing an organization under the additional membership category, the named organization will be contacted in writing and asked to appoint another representative. If the organization fails to appoint another representative within 60 days, the MAC at the next meeting shall consider replacement or removal of the organization from participation on the MAC.

Orientation and Training

All new appointees to the MAC are expected to attend an orientation training session hosted by the OHCA within the first three months of their appointment. This training will include information on the Medicaid, CHIP, SoonerCare, and Insure Oklahoma programs needed to actively and effectively participate on the MAC. The orientation may be conducted in part or whole electronically or through video conferencing capabilities.

OHCA Staff Support to the MAC

The OHCA will maintain a MAC Support Team whose members will staff the MAC. At a minimum, the MAC Support Team will consist of a representative from the major OHCA divisions (Program Operations, Communications and Outreach, Policy and Planning, and Legal). In addition the Chief Medical Officer and his/her administrative support will provide operational support and leadership.

Annual Review

The MAC as well as the OHCA MAC Support Team shall review these guidelines on an annual basis. Proposed changes shall be discussed and voted on by the MAC members.

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
For the Fiscal Year Ended June 30, 2011

REVENUES	FY11 Budget YTD	FY11 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 699,875,770	$ 699,875,770	$ -	0.0%
Federal Funds	2,115,092,395	2,073,830,058	(41,262,337)	(2.0)%
Tobacco Tax Collections	53,713,078	55,263,071	1,549,993	2.9%
Quality of Care Collections	50,887,705	51,685,588	797,883	1.6%
Prior Year Carryover	45,663,786	35,663,786	(10,000,000)	(21.9)%
HEEIA Fund Transfer	30,000,000	30,000,000	-	0.0%
Federal Deferral - Interest	240,652	240,652	-	0.0%
Drug Rebates	126,972,460	144,445,661	17,473,201	13.8%
Medical Refunds	42,032,295	48,954,797	6,922,502	16.5%
Other Revenues	17,278,020	15,934,029	(1,343,991)	(7.8)%
Stimulus Funds Drawn	76,891,075	76,891,075	-	0.0%
TOTAL REVENUES	**$ 3,258,647,236**	**$ 3,232,784,486**	**$ (25,862,750)**	**(0.8)%**

EXPENDITURES	FY11 Budget YTD	FY11 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 43,203,581**	**$ 39,749,255**	**$ 3,454,326**	**8.0%**
ADMINISTRATION - CONTRACTS	**$ 107,739,430**	**$ 94,790,337**	**$ 12,949,093**	**12.0%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	31,086,445	27,704,320	3,382,125	10.9%
Acute Fee for Service Payments:				
Hospital Services	908,883,554	884,624,104	24,259,449	2.7%
Behavioral Health	289,173,372	294,236,735	(5,063,362)	(1.8)%
Physicians	402,786,689	429,973,484	(27,186,795)	(6.7)%
Dentists	158,941,061	145,049,364	13,891,697	8.7%
Other Practitioners	54,832,203	62,850,365	(8,018,162)	(14.6)%
Home Health Care	22,002,021	21,366,561	635,460	2.9%
Lab & Radiology	48,062,748	48,885,974	(823,226)	(1.7)%
Medical Supplies	52,501,386	48,038,762	4,462,625	8.5%
Ambulatory Clinics	95,144,579	81,709,959	13,434,620	14.1%
Prescription Drugs	362,170,698	347,295,230	14,875,468	4.1%
Miscellaneous Medical Payments	30,009,791	32,439,891	(2,430,100)	(8.1)%
OHCA TFC	-	2,804,311	(2,804,311)	0.0%
Other Payments:				
Nursing Facilities	493,089,933	488,557,385	4,532,549	0.9%
ICF-MR Private	54,482,140	55,763,912	(1,281,772)	(2.4)%
Medicare Buy-In	136,566,184	138,460,083	(1,893,899)	(1.4)%
Transportation	27,470,618	27,364,951	105,667	0.4%
HIT-Incentive Payments	35,356,709	35,356,709	-	0.0%
Part D Phase-In Contribution	70,726,392	68,908,484	1,817,908	2.6%
Total OHCA Medical Programs	**3,273,286,525**	**3,241,390,584**	**31,895,941**	**1.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,424,318,918**	**$ 3,375,930,176**	**$ 48,388,742**	**1.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (165,671,682)**	**$ (143,145,690)**	**$ 22,525,991**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
For the Fiscal Year Ended June 30, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 28,124,725	$ 27,682,175	$ -	$ 420,406	$ -	$ 22,145	$ -
Inpatient Acute Care	867,845,298	598,531,747	486,687	12,096,871	48,945,161	4,700,144	203,084,688
Outpatient Acute Care	241,400,269	226,206,701	41,604	9,439,904	-	5,712,060	
Behavioral Health - Inpatient	120,407,904	115,828,718	-	3,585	-	6,033	4,569,569
Behavioral Health - Outpatient	10,258,121	10,186,791	-	-	-	-	71,330
Behavioral Health Facility- Rehab	232,373,614	168,050,638	-	393,778	-	164,337	63,764,860
Behavioral Health - Case Management	218	149	-	-	-	69	
Residential Behavioral Management	22,824,691	-	-	-	-	-	22,824,691
Targeted Case Management	73,372,701	-	-	-	-	-	73,372,701
Therapeutic Foster Care	2,804,311	2,804,311	-	-	-	-	-
Physicians	481,048,787	361,371,667	58,101	14,033,364	58,511,325	10,032,391	37,041,939
Dentists	145,083,075	137,076,690	-	33,711	7,861,061	111,613	-
Other Practitioners	63,365,189	61,432,253	446,364	514,825	921,222	50,526	-
Home Health Care	21,366,642	21,309,836	-	80	-	56,725	-
Lab & Radiology	51,870,694	47,415,554	-	2,984,720	-	1,470,420	-
Medical Supplies	48,632,189	45,223,440	2,717,836	593,427	-	97,486	-
Ambulatory Clinics	94,965,751	81,053,751	-	1,678,040	-	656,207	11,577,752
Personal Care Services	12,339,918	-	-	-	-	-	12,339,918
Nursing Facilities	488,557,385	312,149,963	136,180,339	-	40,191,129	35,953	-
Transportation	27,364,951	24,818,314	2,475,273	-	62,266	9,099	-
GME/IME/DME	103,621,761	-	-	-	-	-	103,621,761
ICF/MR Private	55,763,912	45,767,306	9,156,952	-	839,654	-	-
ICF/MR Public	71,031,664	-	-	-	-	-	71,031,664
CMS Payments	207,368,567	204,775,499	2,593,068	-	-	-	-
Prescription Drugs	363,451,507	301,830,879	-	16,156,277	42,932,030	2,532,321	-
Miscellaneous Medical Payments	32,440,068	30,922,849	-	177	1,386,077	130,965	-
Home and Community Based Waiver	155,883,549	-	-	-	-	-	155,883,549
Homeward Bound Waiver	90,062,006	-	-	-	-	-	90,062,006
Money Follows the Person	4,607,090	-	-	-	-	-	4,607,090
In-Home Support Waiver	24,163,755	-	-	-	-	-	24,163,755
ADvantage Waiver	181,598,864	-	-	-	-	-	181,598,864
Family Planning/Family Planning Waiver	7,751,676	-	-	-	-	-	7,751,676
Premium Assistance*	52,293,180	-	-	52,293,180	-	-	-
HIT Grant Incentive Payments	35,356,709	35,356,709					
Total Medicaid Expenditures	**$ 4,419,400,740**	**$2,859,795,942**	**$ 154,156,223**	**$ 110,642,345**	**$ 201,649,925**	**$ 25,788,494**	**$ 1,067,367,812**

* Includes $52,025,569.51 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
For the Fiscal Year Ended June 30, 2011

REVENUE		FY11 Actual YTD
Revenues from Other State Agencies	$	425,716,467
Federal Funds		694,855,878
TOTAL REVENUES	**$**	**1,120,572,345**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	155,883,549
Money Follows the Person		4,607,090
Homeward Bound Waiver		90,062,006
In-Home Support Waivers		24,163,755
ADvantage Waiver		181,598,864
ICF/MR Public		71,031,664
Personal Care		12,339,918
Residential Behavioral Management		17,489,146
Targeted Case Management		55,614,541
Total Department of Human Services		**612,790,532**
State Employees Physician Payment		
Physician Payments		37,041,939
Total State Employees Physician Payment		**37,041,939**
Education Payments		
Graduate Medical Education		53,350,000
Graduate Medical Education - PMTC		5,217,572
Indirect Medical Education		28,813,252
Direct Medical Education		16,240,937
Total Education Payments		**103,621,761**
Office of Juvenile Affairs		
Targeted Case Management		3,061,869
Residential Behavioral Management - Foster Care		56,689
Residential Behavioral Management		5,278,856
Multi-Systemic Therapy		71,330
Total Office of Juvenile Affairs		**8,468,745**
Department of Mental Health		
Targeted Case Management		98
Hospital		4,569,569
Mental Health Clinics		63,764,860
Total Department of Mental Health		**68,334,527**
State Department of Health		
Children's First		2,115,798
Sooner Start		2,479,855
Early Intervention		6,381,866
EPSDT Clinic		2,132,293
Family Planning		88,318
Family Planning Waiver		7,611,580
Maternity Clinic		76,751
Total Department of Health		**20,886,461**
County Health Departments		
EPSDT Clinic		745,803
Family Planning Waiver		51,778
Total County Health Departments		**797,581**
State Department of Education		**140,585**
Public Schools		**6,057,943**
Medicare DRG Limit		**198,242,117**
Native American Tribal Agreements		**6,143,051**
Department of Corrections		**162,290**
JD McCarty		**4,680,281**
Total OSA Medicaid Programs	**$**	**1,067,367,812**
OSA Non-Medicaid Programs	**$**	**74,083,119**
Accounts Receivable from OSA	**$**	**20,878,586**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

For the Fiscal Year Ended June 30, 2011

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 51,641,881**	**$ 51,641,881**
Interest Earned	**43,707**	**43,707**
TOTAL REVENUES	**$ 51,685,588**	**$ 51,685,588**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 132,428,198	$ 46,601,483	
Eyeglasses and Dentures	288,981	101,693	
Personal Allowance Increase	3,463,160	1,218,686	
Coverage for DME and supplies	2,717,836	956,406	
Coverage of QMB's	1,032,756	363,427	
Part D Phase-In	2,593,068	2,593,068	
ICF/MR Rate Adjustment	4,878,714	1,716,819	
Acute/MR Adjustments	4,278,238	1,505,512	
NET - Soonerride	2,475,273	871,048	
Total Program Costs	**$ 154,156,223**	**$ 55,928,142**	**$ 55,928,142**
Administration			
OHCA Administration Costs	$ 555,990	$ 277,995	
DHS - 10 Regional Ombudsman	242,662	242,662	
OSDH-NF Inspectors	358,163	358,163	
Mike Fine, CPA	20,000	10,000	
Total Administration Costs	**$ 1,176,815**	**$ 888,820**	**$ 888,820**
Total Quality of Care Fee Costs	**$ 155,333,038**	**$ 56,816,962**	
TOTAL STATE SHARE OF COSTS			**$ 56,816,962**

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
For the Fiscal Year Ended June 30, 2011

REVENUES	FY 10 Carryover	FY 11 Revenue	Total Revenue
Prior Year Balance	$ 45,276,770	$ -	$ 7,634,205
State Appropriations	(30,000,000)		
Tobacco Tax Collections	-	45,452,046	45,452,046
Interest Income	-	987,819	987,819
Federal Draws	383,873	35,473,225	35,473,225
All Kids Act	(7,593,211)	406,789	406,789
TOTAL REVENUES	**$ 8,067,432**	**$ 82,319,878**	**$ 89,547,294**

EXPENDITURES	FY 10 Expenditures	FY 11 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 51,638,636	$ 51,638,636
College Students		267,610	267,610
All Kids Act		386,934	386,934
Individual Plan			
SoonerCare Choice		$ 411,475	$ 144,798
Inpatient Hospital		12,036,052	4,235,487
Outpatient Hospital		9,332,682	3,284,171
BH - Inpatient Services		3,585	1,261
BH Facility - Rehabilitation Services		391,389	137,730
Physicians		13,907,088	4,893,904
Dentists		23,405	8,236
Other Practitioners		503,001	177,006
Home Health		80	28
Lab and Radiology		2,948,626	1,037,621
Medical Supplies		591,543	208,164
Ambulatory Clinics		1,659,207	583,875
Prescription Drugs		16,009,667	5,633,802
Miscellaneous Medical		177	62
Premiums Collected		-	(2,224,819)
Total Individual Plan		**$ 57,817,978**	**$ 18,121,327**
College Students-Service Costs		**$ 474,764**	**$ 167,069**
All Kids Act- Service Costs		**$ 56,423**	**$ 19,855**
Total Program Costs		**$ 110,642,345**	**$ 70,601,432**
Administrative Costs			
Salaries	$ 22,395	$ 1,468,431	$ 1,490,826
Operating Costs	117,115	187,763	304,878
Health Dept-Postponing	29,637	-	29,637
Contract - HP	264,080	2,979,613	3,243,693
Total Administrative Costs	**$ 433,227**	**$ 4,635,807**	**$ 5,069,034**
Total Expenditures			**$ 75,670,466**
NET CASH BALANCE	**$ 7,634,205**		**$ 13,876,828**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
For the Fiscal Year Ended June 30, 2011

REVENUES	FY 11 Revenue	State Share
Tobacco Tax Collections	$ 907,101	$ 907,101
TOTAL REVENUES	**$ 907,101**	**$ 907,101**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 22,145	$ 5,454	
Inpatient Hospital	4,700,144	1,157,645	
Outpatient Hospital	5,712,060	1,406,880	
Inpatient Free Standing	6,033	1,486	
MH Facility Rehab	164,337	40,476	
Case Mangement	69	17	
Nursing Facility	35,953	8,855	
Physicians	10,032,391	2,470,978	
Dentists	111,613	27,490	
Other Practitioners	50,526	12,444	
Home Health	56,725	13,971	
Lab & Radiology	1,470,420	362,164	
Medical Supplies	97,486	24,011	
Ambulatory Clinics	656,207	161,624	
Prescription Drugs	2,532,321	623,711	
Transportation	9,099	2,241	
Miscellaneous Medical	130,965	32,257	
Total Program Costs	$ 25,788,494	$ 6,351,706	**$ 6,351,706**
TOTAL STATE SHARE OF COSTS			**$ 6,351,706**

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.

FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2011
Submitted to the CEO & Board
August 24, 2011

- Revenues for OHCA through June, accounting for receivables, were **$3,232,784,486** or **(.8%) under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$3,375,930,176** or **1.4% under** budget.

- The state dollar budget variance through June is **$22,525,991 positive.**

- The prior year carryover was reduced by **$10,000,000** due to the Office of State Finance redistribution of State Fiscal Stabilization Funds.

- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		14.4
Administration		7.7
Revenues:		
Prior Year-Reduction		(10.0)
Taxes and Fees		2.3
Drug Rebate		6.1
Overpayments/Settlements		2.0
Total FY 11 Variance	**$**	**22.5**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 230: Quality of Care Fund Summary 4
Fund 245: Health Employee and Economy Act Revolving Fund 5
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund 6

OKLAHOMA HEALTH CARE AUTHORITY
FY12 BUDGET WORK PROGRAM
Summary by Program Expenditure

Description	FY-11	FY-12	Inc / (Dec)	% Change
Medical Program				
Managed Care - Choice	31,086,445	32,187,142	1,100,697	3.5%
Hospitals	908,883,554	934,025,971	25,142,417	2.8%
Behavioral Health	289,173,372	293,286,847	4,113,474	1.4%
Nursing Homes	493,089,933	476,842,860	(16,247,073)	-3.3%
Physicians	402,786,689	422,131,134	19,344,446	4.8%
Dentists	158,941,061	141,325,524	(17,615,537)	-11.1%
Other Practitioners	54,832,203	58,224,732	3,392,530	6.2%
Home Health	22,002,021	21,717,035	(284,986)	-1.3%
Lab & Radiology	48,062,748	48,859,558	796,811	1.7%
Medical Supplies	52,501,386	47,843,074	(4,658,312)	-8.9%
Clinics	95,144,579	88,801,285	(6,343,294)	-6.7%
Prescription Drugs	362,170,698	362,976,536	805,838	0.2%
Miscellaneous	30,009,791	32,826,294	2,816,503	9.4%
ICF-MR Private	54,482,140	55,092,542	610,402	1.1%
Transportation	27,470,618	28,211,700	741,082	2.7%
Medicare Buy-in	136,566,184	149,030,462	12,464,277	9.1%
MMA clawback payment	70,726,392	75,219,620	4,493,229	6.4%
HIT Grant Incentive Payments	37,358,736	73,854,823	36,496,087	97.7%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	3,275,377,933	3,342,546,523	67,168,590	2.1%
OEPIC - Premium Assistance (HIFA)				
Employer Sponsored Insurance - ESI	57,318,322	58,797,620	1,479,298	2.6%
Individual Plan - IP	64,648,296	52,850,549	(11,797,747)	-18.2%
TOTAL O-EPIC PROGRAM	121,966,618	111,648,169	(10,318,449)	-8.5%
OHCA Administration				
Operations	43,826,800	44,119,302	292,502	0.7%
Contracts	100,752,148	105,155,212	4,403,064	4.4%
HIFA admin	8,493,670	8,288,503	(205,167)	-2.4%
Grant Mgmt	8,832,942	11,308,811	2,475,869	28.0%
TOTAL OHCA ADMIN	161,905,559	168,871,827	6,966,267	4.3%
TOTAL OHCA PROGRAMS	**3,559,250,111**	**3,623,066,520**	**63,816,409**	**1.8%**
Other State Agency (OSA) Programs				
DHS	650,073,310	616,826,445	(33,246,866)	-5.1%
ODSH	23,059,295	20,595,099	(2,464,196)	-10.7%
OJA	8,580,495	8,204,395	(376,100)	-4.4%
University Hospitals	325,541,782	324,618,843	(922,940)	-0.3%
PMTC	5,246,424	5,529,093	282,669	5.4%
DMHSAS	47,769,491	70,803,189	23,033,698	48.2%
DOE	6,773,443	5,560,780	(1,212,663)	-17.9%
OSA DSH Supplemental	34,424,424	-	(34,424,424)	0.0%
Non-Indian Payments	3,299,210	6,151,670	2,852,460	86.5%
DOC	118,564	136,673	18,109	15.3%
JD McCarty	3,430,466	3,530,139	99,674	0.0%
OSA Non-Title XIX	101,659,710	101,659,710	-	0.0%
SHOPP hospital payments	-	338,000,000	338,000,000	100.0%
TOTAL OSA PROGRAMS	**1,209,976,615**	**1,501,616,037**	**291,639,422**	**24.1%**
TOTAL MEDICAID PROGRAM	**4,769,226,726**	**5,124,682,557**	**355,455,831**	**7.5%**

OKLAHOMA HEALTH CARE AUTHORITY
FY12 BUDGET WORK PROGRAM
Summary by Program Expenditure

Description	FY-11	FY-12	Inc / (Dec)	% Change
REVENUES				
Federal - program	2,818,943,155	3,006,082,887	187,139,732	6.6%
Federal Stimulus funds (ARRA)	278,139,950	70,866,174	(207,273,776)	-74.5%
Federal - admin	95,390,113	100,254,264	4,864,151	5.1%
Drug Rebates	126,972,460	149,297,201	22,324,741	17.6%
Medical Refunds	42,032,295	40,350,874	(1,681,421)	-4.0%
NF Quality of Care Fee	51,470,446	51,175,731	(294,715)	-0.6%
OSA Refunds & Reimbursements	509,326,469	621,781,272	112,454,803	22.1%
Tobacco Tax	97,271,754	95,576,605	(1,695,150)	-1.7%
Insurance Premiums	7,757,796	6,342,066	(1,415,730)	100.0%
Misc Revenue	3,084,000	3,284,000	200,000	6.5%
Prior Year Carryover	1,371,872	30,003,490	28,631,618	2087.0%
Other Grants	7,590,645	7,648,605	57,959	0.8%
Hospital Provider Fee (SHOPP bill)	-	29,800,000	29,800,000	100.0%
OEPIC Transfer	30,000,000	-	(30,000,000)	100.0%
State Appropriated	699,875,770	912,219,389	212,343,619	30.3%
TOTAL REVENUES	**4,769,226,726**	**5,124,682,557**	**355,455,831**	**7.5%**

SoonerCare Programs

July 2011 Data for September 2011 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2011	Enrollment July 2011	Total Expenditures July 2011	Average Dollars Per Member Per Month July 2011
SoonerCare Choice Patient-Centered Medical Home		448,901	**443,013**	**$105,392,978**	
Lower Cost	*(Children/Parents; Other)*		397,328	$69,428,621	$175
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		45,685	$35,964,358	$787
SoonerCare Traditional		239,578	**243,228**	**$173,617,451**	
Lower Cost	*(Children/Parents; Other)*		137,419	$50,597,982	$368
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		105,809	$123,019,469	$1,163
SoonerPlan		31,531	**36,916**	**$536,492**	$15
Insure Oklahoma		32,200	**32,431**	**$8,957,031**	
Employer-Sponsored Insurance		19,056	18,591	$4,445,154	$239
Individual Plan		13,143	13,840	$4,511,877	$326
TOTAL		**752,210**	**755,588**	**$288,503,953**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $22,924,932 are excluded.

Net Enrollee Count Change from Previous Month Total	3,004

New Enrollees	21,275

Opportunities for Living Life (OLL) (subset of data above)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,816
Aged/Blind/Disabled	*Adult*	129,886
Other	*Child*	144
Other	*Adult*	19,912
PACE	*Adult*	79
TEFRA	*Child*	395
Living Choice	*Adult*	121
OLL Enrollment		**170,353**

The "Other" category includes DDSD State, PKU, Q1, Q2, Refugee, SLMB, Soon-to-be-Sooners (STBS) and TB members.

Medicare and SoonerCare	Monthly Average SFY2011	Enrolled July 2011
Dual Enrollees	**103,906**	**105,656**

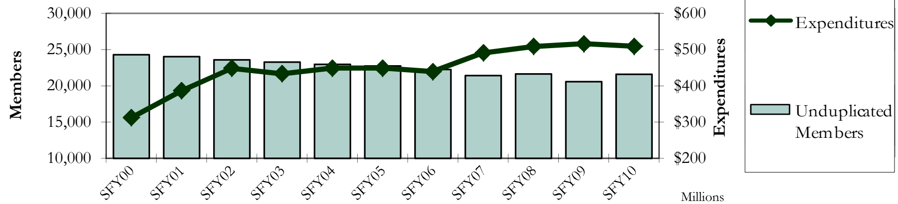
		Monthly Average SFY2011	Enrolled July 2011	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,746**	**$3,159**
	Child	92	97	
	Adult	15,641	15,649	

SFY2010 Long-Term Care

Statewide LTC Occupancy Rate - 69.8%
SoonerCare funded LTC Bed Days 68.6%

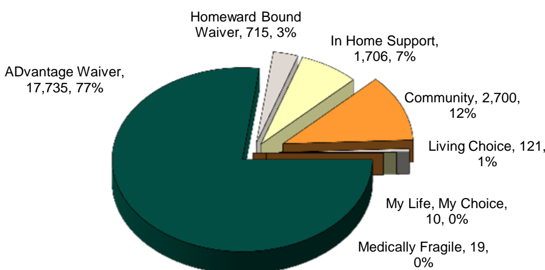
Data as of September 2010

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Oct. 15, 2010. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

Waiver Enrollment Breakdown Percent



ADvantage Waiver - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.
Community - serves individuals 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded/intellectually disabled (ICF/MR).
Homeward Bound Waiver - Designed to serve the needs of individuals with intellectual disabilities or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/MR.
In Home Support - Serves the needs of individuals 3 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/MR.
Living Choice - Promotes community living for people of all ages who have disabilities or long-term illnesses.
Medically Fragile - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.
My Life, My Choice - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2011	Enrolled July 2011
Total Providers		**29,026**	**31,143**
	In-State	20,585	21,669
	Out-of-State	8,442	9,474

Program	% of Capacity Used
SoonerCare Choice	40%
SoonerCare Choice I/T/U	12%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled July 2011***	Total Monthly Average SFY2011	Total Enrolled July 2011
Physician	*6,489*	*6,974*	*11,777*	12,929
Pharmacy	*901*	*864*	*1,230*	1,133
Mental Health Provider	*935*	*969*	*982*	1,014
Dentist	*798*	*932*	*901*	1,054
Hospital	*187*	*188*	*739*	843
Licensed Behavioral Health Practitioner	*503*	*589*	*524*	620
Extended Care Facility	*392*	*391*	392	391

*The In-State Monthly Averages above were recalculated due to a change in the original methodology.

Total Primary Care Providers	*4,461*	*4,858*	6,467	7,038
Patient-Centered Medical Home	*1,476*	*1,525*	1,502	1,553

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

**Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

	July 2011		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	96	$2,040,000	700	$14,974,167
Eligible Hospitals	1*	$325,000	34	$23,023,793
Totals	97	$2,365,000	734	$37,997,960

*Current Eligible Hospitals Paid
JEFFERSON COUNTY HOSPITAL

Care Coordination Oversight Project Evaluation Study

Presented by
Debbie Spaeth, LMFT, LPC, LADC
Behavioral Health Director

STUDY PURPOSE

To see if state agency level care management of high resource utilization children results in decreased inpatient usage, increased community based services, and decreased overall healthcare costs.

PROJECT PARTNERS

- Oklahoma Health Care Authority (OHCA)
- Oklahoma Department of Human Services (OK DHS)
- Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)
- Oklahoma Office of Juvenile Affairs (OJA)
- Oklahoma Commission on Children and Youth (OCCY)
- Oklahoma Department of Rehabilitation Services (DRS)
- Oklahoma Federation of Families
- APS Healthcare, Inc.
- E-TEAM, University of Oklahoma Outreach
- Funded by Transformation System Infrastructure Grant

GOALS

- Better Coordinated Services
- Decrease Psychological Impairment
- Increase Member Satisfaction
- Increase Community Based Services
- Decrease Inpatient Days
- Decrease Discharge to First service (avg 52 days to w/in 7 days)
- Increase Community Crisis Response

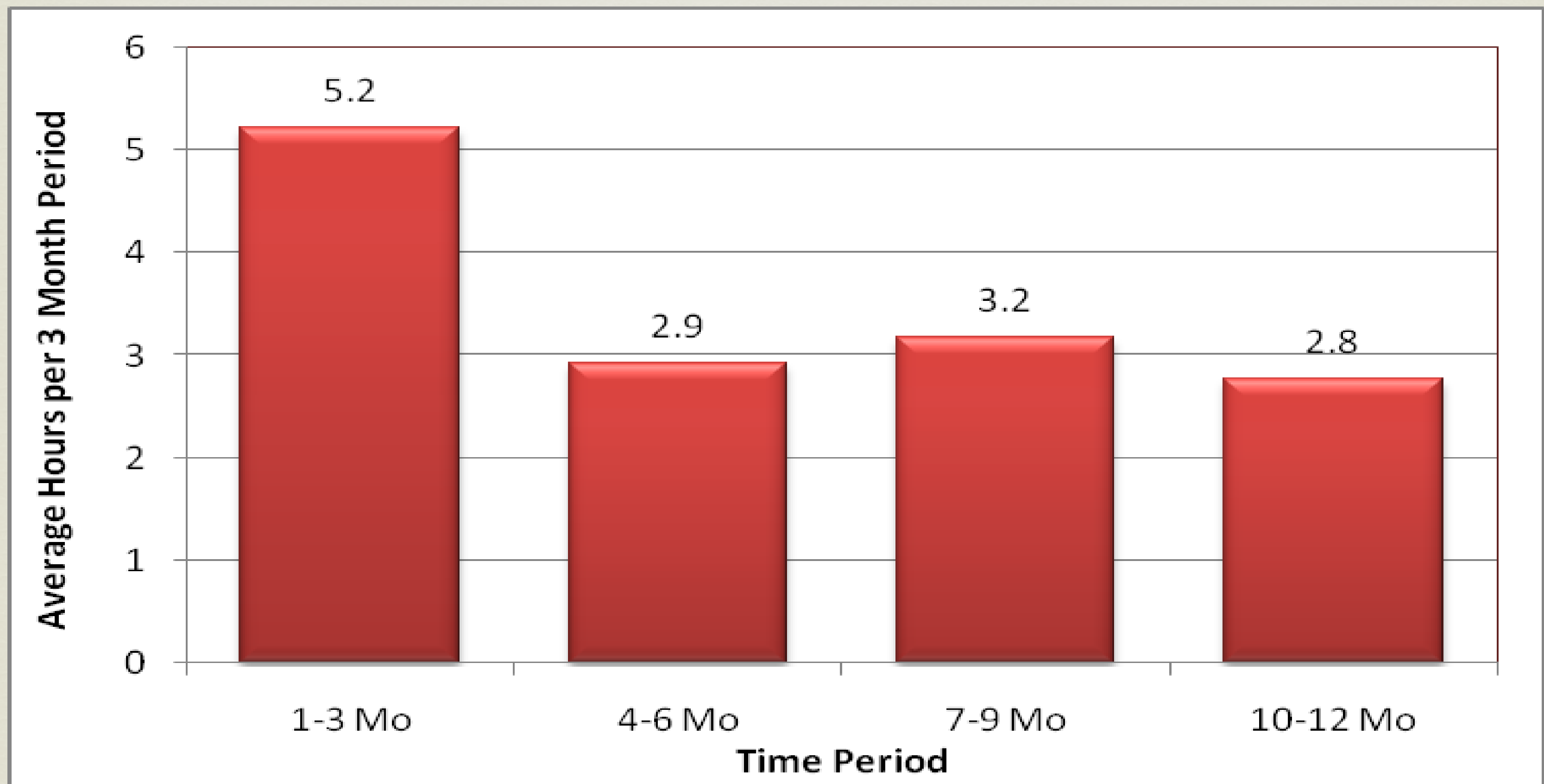
Evaluation Study

- Randomized Control Trial
- Children chosen based on high risk of future hospitalizations
- 1,943 projected high-resource utilization youth 6-18 years of age
- Youth were randomly assigned to the:
  - Care Mgmt (CM)/Treatment Group (N=87); or
  - Control Group (CG) (N=90)
- Compared outcomes of CM group to CG

Care Management

- Collaborative approach between agencies, community providers, and members/families
- Activities:
  - Agreement to Participate
  - Assessment
  - Monitoring of Service Plan & appointments
  - Follow-up Calls & Advocacy
  - State level support of community based providers
  - Reporting Gaps and Barriers

Avg. CM hrs per Participant by Tx Period

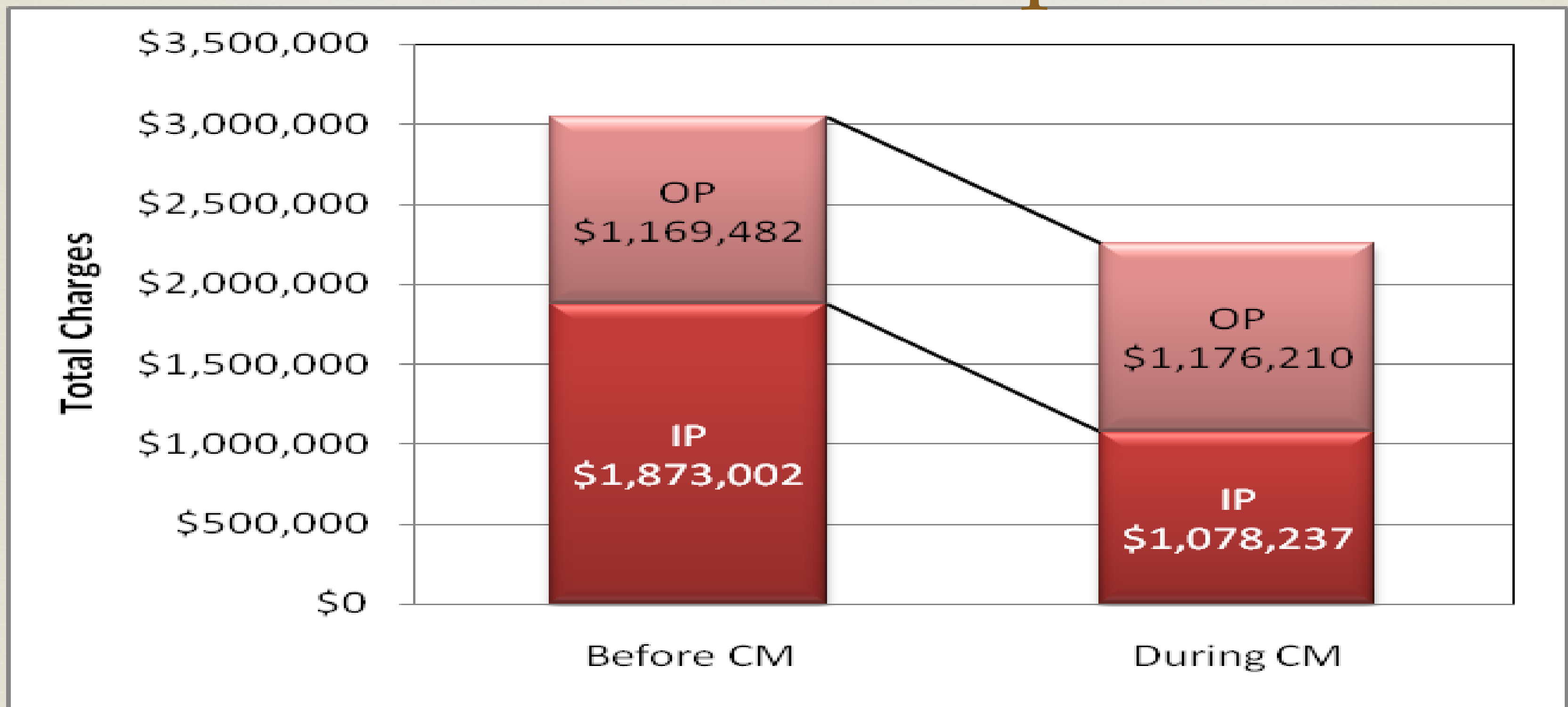


Avg - 1.7 hrs PMPM for months 1-3, then 1 hr PMPM 4-12

Goals Achieved

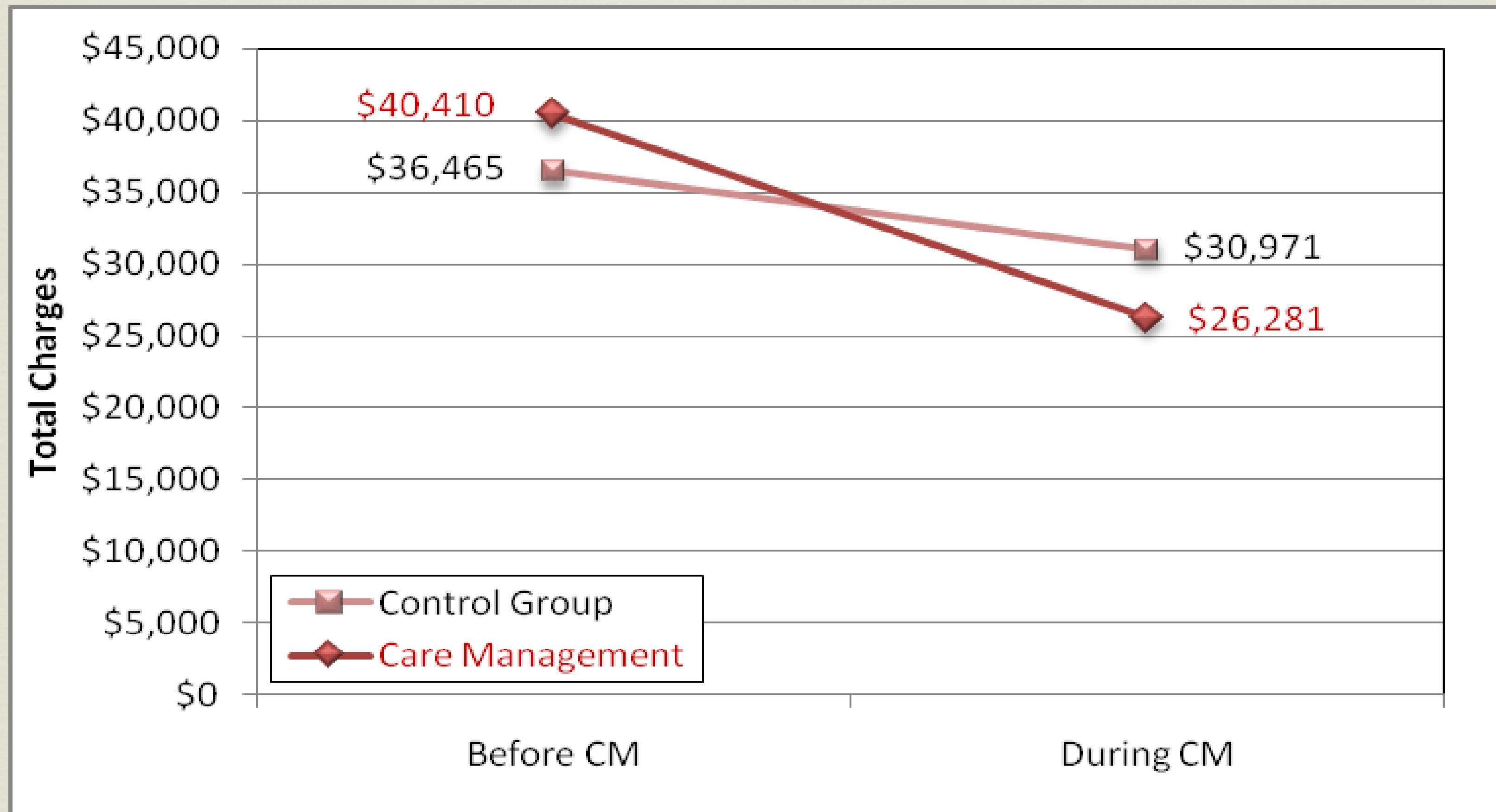
GOAL	CARE MGMT GROUP	CONTROL GROUP
Decrease Impairment Scores	5% Decrease	20% Increase
Increase Satisfaction w/Services Scores	31 % Increase	2% Increase
Decrease Inpatient Costs	60% Decrease	17% Decrease
Decrease Days in Inpatient	Decreased 42 days	Decreased 8 days
Increase Community Based Services	16% Increase	12% Decrease
Decrease Time to First Appointment	78% w/in 7 days	73% w/in 7 days

Total Healthcare Costs Results – CM Group



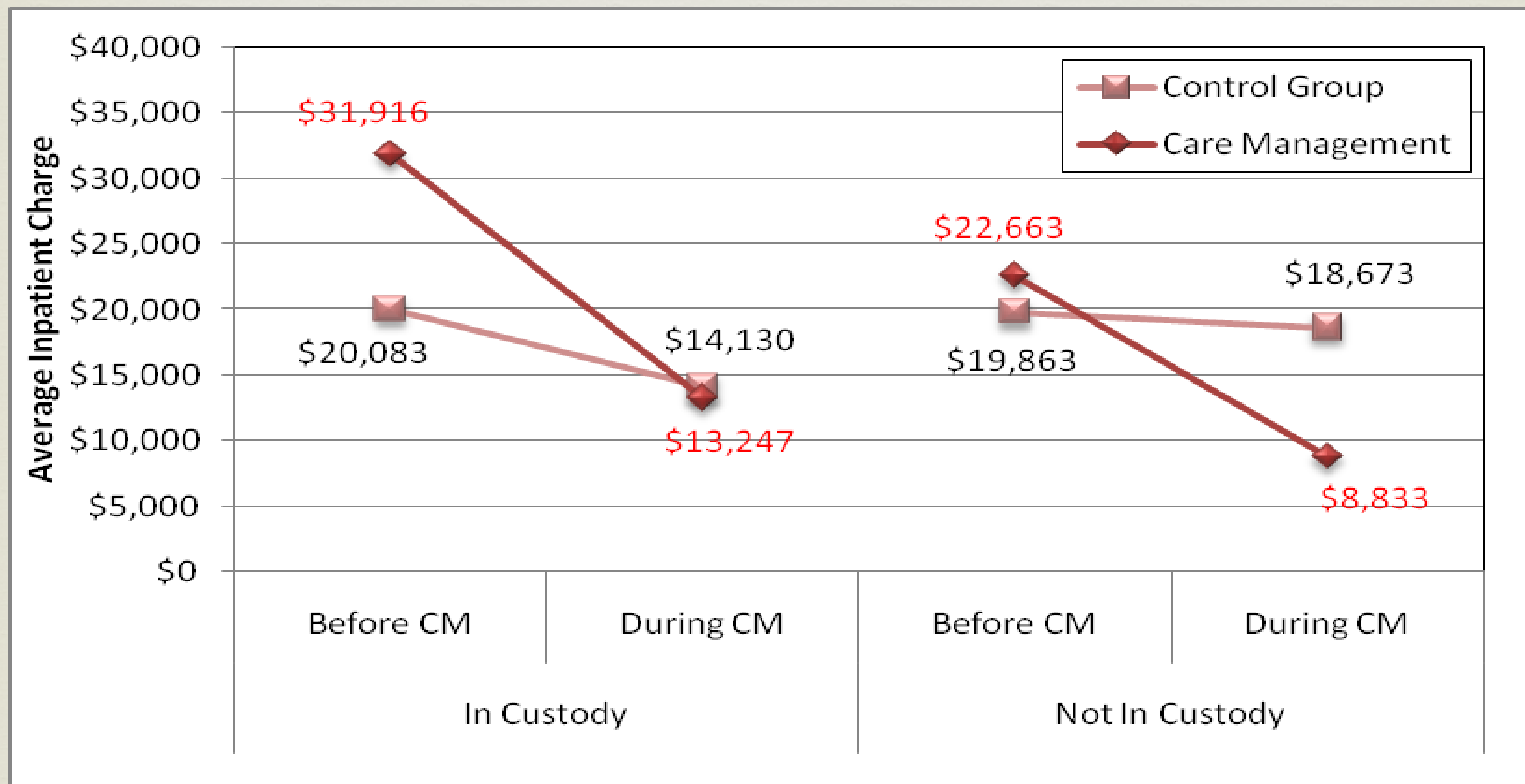
Total costs decreased for the 12 month time period from $3,042,484 in the year prior to Care Management to $2,254,447 during the year of Care Management . This is a 41% decrease in inpatient and 1% increase in outpatient costs.

Average Total Charges per Member



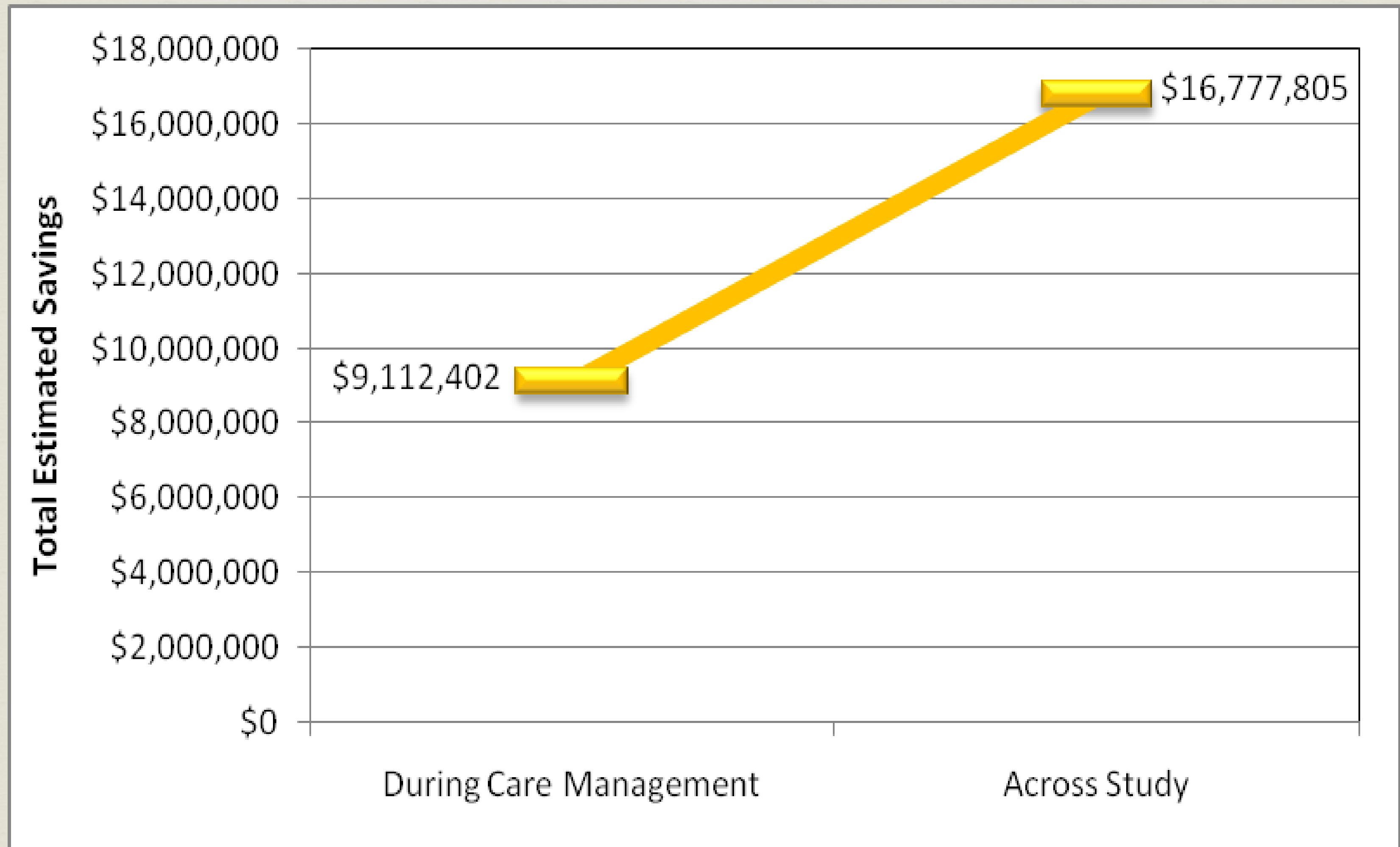
The cost difference between CM and CG in before CM status are not statistically significant (p>.05)

AVERAGE INPATIENT CHARGES BY GROUP, TIME PERIOD AND CUSTODY STATUS



Custody: 58% reduction in average inpatient charges for the CM group compared to a 30% reduction for the CG .
Non-Custody: 61% reduction in average inpatient charges for the CM compared to a 6% reduction for the Control Group.

Estimated Savings for the 1,943



Recommendations

- Fully Fund the Care Management Program
  - Cost Savings $9 Million (1,943 children)
  - Cost of Program $2 Million (20 FTE + 2 Supervisors)
  - **Net Savings $7 Million**

- Benefit to Cost Ratio – **3.5**
  - (*$3.50 saved to every $1 spent on the program)

To view the full report for the Care Management Oversight Project Evaluation Study, visit the OU E-TEAM website at http://eteam.ou.edu and view our behavioral health projects page.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and Cost Sharing

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

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to

the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.

(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee for service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age 21. Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities and intermediate care facilities for the mentally retarded.

~~(C) Pregnant women.~~

~~(D)~~(C) Home and Community Based Service waiver members except for prescription drugs.

~~(E)~~(D) Native Americans providing documentation of ethnicity in accordance with 317:35-5-25 who receive items

and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

(2) Co-payment is not required for the following services:

(A) Family planning services. Includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

<u>(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.</u>

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians,

(ii) Advanced Practice Nurses,

(iii) Physician Assistants,

(iv) Optometrists,

(v) Home Health Agencies,

(vi) Certified Registered Nurse Anesthetists,

(vii) Anesthesiologist Assistants,

(viii) Durable Medical Equipment providers, and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(i) Zero for preferred generics.

(ii) $0.65 for prescriptions having a SoonerCare allowable payment of $0.00-$10.00.

(iii) $1.20 for prescriptions having a SoonerCare allowable payment of $10.01-$25.00.

(iv) $2.40 for prescriptions having a SoonerCare allowable payment of $25.01-$50.00.

(v) $3.50 for prescriptions having a SoonerCare allowable payment of $50.01 or more.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.2. Medical necessity

(a) **Coverage.** Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning ~~or~~ of a malformed body member. The member's diagnosis must warrant the type of equipment or supply being purchased or rented.

(b) **Prescription requirements.** All DME, except for equipment repairs with a cost per item of less than $250.00 total parts and labor and hearing aid batteries, require a prescription signed by a physician, a physician assistant, or an advanced practice nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one year from the date written. The prescription must include the following information:

(1) date of the order;
(2) name and address of the prescriber;
(3) name and address of the member;
(4) name or description and quantity of the prescribed item;
(5) diagnosis for the item requested;
(6) directions for use of the prescribed item; and
(7) prescriber's signature.

(c) **Certificate of medical necessity.** For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be faxed, copied or the original hardcopy.

(d) **Place of service.**

(1) OHCA covers DMEPOS for use in the member's place of residence except if the member's place of residence is a nursing facility.

(2) For members residing in a nursing facility, most medical supplies and/or DME are considered part of the facility's per diem rate. Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-58 Supplemental Hospital Offset Payment Program.

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services. In accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes.

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

(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care Authority (OHCA) if the hospital's data is not included in a Medicare Cost Report.

(2) **"Fee"** means supplemental hospital offset assessment pursuant to Section 3241.1 of Title 63 of the Oklahoma Statutes.

(3) **"Hospital"** means an institution licensed by the State Department of Health as a hospital pursuant to Section 1-701.1 of Title 63 of the Oklahoma Statutes maintained primarily for the diagnosis, treatment, or care of patients;

(4) **"Hospital Advisory Committee"** means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.

(5) **"NET hospital patient revenue"** means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines 16, 17 and 18) of the Medicare Cost Report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)and Worksheet G-2 (Part I, Column 3, Line 25);

(6) **"Medicare Cost Report"** means form CMS-2552-96, the Hospital Cost Report, as it existed on January 1, 2010;

(7) **"Upper payment limit"** means the maximum ceiling imposed by 42 C F R §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and

outpatient services, other than to hospitals owned or operated by state government; and

(8) **"Upper payment limit gap"** means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to 63 Okla. Stat. §§ 3241.1 through 3241.6 the Oklahoma Health Care Authority (OHCA) was mandated to assess hospitals licensed in Oklahoma, unless exempted under (c) (2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

(A) a hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicaid and State operations.

(B) a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C) a hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, using the Inpatient Discharge Data File published by the Oklahoma State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, Using substantially equivalent data provided by the hospital:

(i) treatment of a neurological injury;

(ii) treatment of cancer;

(iii) treatment of cardiovascular disease;

(iv) obstetrical or childbirth services; or

(v) surgical care except that this exemption will not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority

of inpatient days are for back, neck, or spine surgery.

(D) a hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital, according to the most recent list of LTCH's published on the CMS http://www.cms.gov/LongTermCareHospitalPPS/08download.asp or as a children's hospital; and

(E) a hospital that is certified by CMS as a critical access hospital, according to the most recent list published by Flex Monitoring Team for Critical Access Hospital (CAH) Information at http://www.flexmonitoring.org/cahlistRA.cgi,which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) **The Supplemental Hospital Offset Payment Program Assessment.**

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. The assessment rate until December 31, 2012, is two and one-half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%).

(2) OHCA will review and determine the amount of annual assessment in December of each year.

(3) A hospital may not charge any patient for any portion of the SHOPP assessment.

(4) The Method of collection is as follows:

(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.

(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the hospital's net patient revenue calculation, and the assessment amount.

(C) New hospitals will only be added at the beginning of each calendar year.

(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the

applicable quarter (i.e. January 15th, April 15th, etc.)

(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 5% of the amount and interest of 1.25% per month. The SHOPP assessment must be received by OHCA no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the assessment is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA will add to the assessment:

(i) a penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

(ii) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(iii) the quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. In accordance with OAC 317:2-1-15 SHOPP appeals.

(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.

(e) **Supplemental Hospital Offset Payment Program Cost Reports.**

(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the

reports were compiled in accordance with this section.
(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.
(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefits or payment...shall (i) in the case of such statement, representation, failure, or conversion by any person in connection with furnishing (by the person) of items or services for which payment is or may be under this title (42 U.S.C. § 1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both."
(4) Net hospital patient revenue is determined using the data from each hospital's fiscal year 2009 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file.
(5) If a hospital's fiscal year 2009 Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file dated December 31,2010, the hospital will submit a copy of the hospital's 2009 Medicare Cost Report to the Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.
(6) If a hospital commenced operations after the due date for a 2009 Medicare Cost Report, the hospital will submit its initial Medicare Cost Report to Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis. Hospitals whose assessments were based on partial year cost reports will be reassessed the following year using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) **Closure, merger and new hospitals.**

(1) If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and denominator of which is 365. Within 30 days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by November 1,2011 for the 2012 assessment, and for subsequent years' assessment calculation by September 30 of the preceding year.

(g) **Disbursement of payment to hospitals.**

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of the inpatient supplemental payment pool as

reduced by payments distributed in paragraph (1) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital; not to exceed the UPL for the class.

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital; not to exceed the UPL for the class.

(3) If any retrospective audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed. If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
SUBCHAPTER 1. RULES

317:2-1-2. Appeals

(a) **Member Process Overview.**

(1) The appeals process allows a member 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 member 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. '~~ Okla. Stat. § 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) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 C.F.R. Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard

directly by the ALJ. A decision is normally 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 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under 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 ordinarily within 45 days of the close of all evidence in the case.

(E) Unless an exception is provided in 317:2-1-13, the Administrative Law Judge's decision is appealable to OHCA's CEO under 317:2-1-13.

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

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare 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);

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

(G) Appeals which relate to eligibility determinations made by OHCA;

(H) Appeals of insureds participating in Insure Oklahoma which are authorized by 317:45-9-8(a); and

(2) Provider Appeals:

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

(B) Denial of request to disenroll member from provider's SoonerCare Choice 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 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

(D) Petitions for Rulemaking;

(E) Appeals to the decision made by the Contracts manager related to reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;

(F) Drug rebate appeals;

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

(H) Proposed administrative sanction appeals pursuant to 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally 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;

(I) Contract award appeals;

(J) Provider appeals of OHCA audit findings pursuant to 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and

(K) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives.

(L) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.

317:2-1-15. Supplemental Hospital Offset Payment Program (SHOPP) Appeals.

(a) In accordance with Title 63 of the Oklahoma Statutes Section 3241.4 OHCA is authorized to promulgate rules for appeals of annual assessments, fees and penalties to hospitals as defined by the statute. The rules in this Section describe those appeals rights.

(1) OAC 317:30-5-58 subsections (a) through (e) describe the SHOPP Assessments, fees and the penalties for non-payment of the fee or failure to file a cost report, as set out in 63 Okla. Stat. §§ 3241.3 and 3241.4

(2) Appeals filed under this Section are heard by an Administrative Law Judge (ALJ).

(3) To file an appeal, the provider hospital must file an LD-2 form within thirty (30) days of receipt of the notification from OHCA assessing the annual SHOPP Assessment, a fee or penalty. The penalty, fee or assessment is deducted from the hospital's payment if the assessment is unpaid at the time the appeal is filed. If the hospital prevails in the appeal the amount assessed will be returned to the hospital with their payment.

(4) The hearing will be conducted in accordance with OAC 317:2-1-5.

(b) An individual hospital may appeal an individual assessment at the time of its annual assessment. As provided for above in subsection (3), the appeal must be filed within thirty (30) days of receipt of the notification of assessment by OHCA to the hospital. If

the hospital challenges the computation of the hospital's net patient revenue, the assessment rate, or assessment amount then the appeal will proceed in accordance with subsection(4)above.

(c) Individual hospitals that appeal the quarterly assessment are limited to calculation errors in dividing the annual assessment into four (4) parts. Appeals must be filed within thirty 30 days of receipt of the notice of assessment by OHCA to the hospital. The appeal will proceed in accordance with subsection (4) above.

(d) If OHCA determines an overpayment of SHOPP payments has been made to an individual hospital, then the hospital may file an appeal within thirty (30) days of the notice of overpayment. Overpayments are deducted from the hospital's payment. The appeal will proceed in accordance with subsection (4) above.

(e) OHCA recognizes that some individual hospital's claims regarding an inappropriate assessment or overpayment may involve aggregate data. For example an appeal may involve one of the following issues:

(1) total hospitals in the entire SHOPP pool;

(2) total hospitals that are exempt from SHOPP;

(3) total hospitals classified as critical access hospitals;

(4) total net revenue from all hospitals in the pool;

(5) the total amount of monies allocated to each pool in the SHOPP; or

(6) the pro-rata distribution in a pool(s),

(f) If an individual hospital brings an aggregate appeals claim, there are two (2) elements of proof to be met. The ALJ must determine that the hospital can demonstrate by a preponderance of evidence:

(1) that data was made available before the hospital submitted the appeal; and

(2) a specific calculation error has been made statewide that can be shown by the hospital.

(g) The "Upper Payment Limit" and the "Upper Payment limit Gap" are not appealable in the administrative process.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or

supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in Oklahoma Department of Human Services/Aging Services Division (OKDHS/ASD) identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) **Respite.**

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

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.
(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.
(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(3) **Adult Day Health Care.**

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the member. Physical, occupational, ~~respiratory~~ and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Transportation between the member's residence and the service setting is provided as a part of Adult Day Health Care. Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing and/or hair washing will be authorized when an ADvantage waiver member who uses adult day health care requires assistance with bathing and/or hair washing to maintain health and safety.
(B) Adult Day Health Care is a 15-minute unit. No more than 6 hours are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved plan of care.
(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.
(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

(4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent. All services must be prior authorized.

(6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units

of this service a member may receive is limited to the number of units approved on the plan of care.

(7) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

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

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

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or

advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

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

(I) preparing a one-week supply of insulin syringes for a blind diabetic who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse

evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy ~~services~~ Services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational

therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(10) **Physical Therapy ~~services~~ Services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) **Speech and Language Therapy Services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of

therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

~~(12) **Respiratory Therapy Services.** (A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involved use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.~~

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

~~(13)~~ (12) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice care. ADvantage Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of ADvantage Hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ~~ADvantage Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for ADvantage Facility Based Extended Respite.~~

~~Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period.~~ A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

~~(14)~~ (13) **ADvantage Personal Care.**

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

(B) ADvantage Home Care Agency Skilled Nursing staff working in coordination with an ADvantage Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) ADvantage Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

~~(15)~~ (14) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

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

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

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

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the ADvantage approved plan of care.

~~(16)~~ (15) **Consumer-Directed Personal Assistance Services and Support (CD-PASS).**

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing these employer functions. The member:

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

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-

job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASPA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

(v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:

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

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming;

(III) eating including meal preparation and cleanup;

(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;

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

(C) Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred

to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

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

(ii) remove external catheters, inspect skin and reapplication of same;

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

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

(v) use lift for transfers;

(vi) manually assist with oral medications;

(vii) provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;

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

(ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Financial Management Services are program administrative services provided to participating CD-PASS employer/members by the OKDHS/ASD. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

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

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

~~(17)~~ (16) **Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place

or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received ADvantage services but have been referred by the OKDHS/ASD to the Case Management Provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution Transition Case Management services are prior authorized and billed per 15-minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the member served as described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institutional Transition Services may be authorized and reimbursed under the following conditions:

(i) The service is necessary to enable the individual to move from the institution to their home;

(ii) The individual is eligible to receive ADvantage services outside the institutional setting;

(iii) Institutional Transition Services are provided to the individual within 180 days of discharge from the institution;

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

(D) If the member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services ~~authorized and~~ provided are ~~reimbursed as "Medicaid administrative" costs and providers follow special procedures specified by the OKDHS/ASD to bill for services provided~~ not reimbursable.

~~(18)~~ (17) **Assisted Living Services.**

(A) Assisted Living Services are personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance (to the extent permitted under State law). The assisted living services provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center. Nursing services are incidental rather than integral to the

provision of assisted living services. ADvantage reimbursement for Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the participant as determined through individualized assessment and documented on the participant's service plan.

(B) The ADvantage Assisted Living Services philosophy of service delivery promotes service member choice, and to the greatest extent possible, service member control. Members have control over their living space and choice of personal amenities, furnishing and activities in their residence. The Assisted Living Service provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery that emphasizes member dignity, privacy, individuality, and independence.

(C) ADvantage Assisted Living required policies for Admission/Termination of services and definitions.

(i) ADvantage-certified Assisted Living Centers (ALCs) are required to accept all eligible ADvantage members who choose to receive services through the ALC subject only to issues relating to:

(I) unit availability;

(II) the compatibility of the participant with other residents; and

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

(ii) The ALC may specify the number of units the provider is making available to service ADvantage participants.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate individuals who have

behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage Case Manager, the member and/or member's designated representative and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy and dignity. Inability to meet those needs will not be recognized as a reason for determining that an ADvantage participant's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the description of assisted living center services in the Oklahoma State Department of Health regulations (OAC 310:663-3-3) except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the following services:

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

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to members' needs and choices; and

(III) Arrange or coordinate transportation to and from medical appointments.

(vi) The provider may offer any specialized service or unit for residents with Alzheimer's disease and related dementias, physical disabilities or other special needs that the facility intends to market.

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

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

(ix) The specific Assisted Living Services assistance provided along with amount and duration of each type of

assistance is based upon the individual member's assessed need for service assistance and is specified in the ALC's service plan which is incorporated as supplemental detail into the ADvantage comprehensive service plan. The ADvantage Case Manager in cooperation with the Assisted Living Center professional staff develops the service plan to meet member needs. As member needs change, the service plan is amended consistent with the assessed, documented need for change in services.

(x) Definition of Inappropriate ALC Placement. Placement or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the following conditions exist:

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

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

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

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

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the assisted living center must inform the member and/or the member's representative, if any, and the member's ADvantage Case Manager. The ALC must develop a discharge plan in consultation with the member, the member's support network and the ADvantage Case Manager. The ALC and Case Manager must ensure that the discharge plan includes strategies for providing increased services, when appropriate to minimize risk and meet the higher care needs of members

awaiting a move out of the ALC, if reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage Case Manager, giving the member 30 days notice of the ALC's intent to terminate the residency agreement and move the member to a more appropriate care provider. The 30 day requirement shall not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when termination of the residency agreement is necessary for the physical safety of the member or other residents of the ALC. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

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

(II) the date of the notice;

(III) the date notice was given to the member and the member's representative;

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

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

(D) ADvantage Assisted Living Services provider standards in addition to licensure standards.

(i) Physical environment

(I) The ALC must provide lockable doors on the entry door of each unit and a lockable compartment within each member unit for valuables. Member residents must have exclusive rights to their units with lockable doors at the entrance of their individual and/or shared unit except in the case of documented contraindication. Units may be shared only if a request to do so is initiated by the member resident.

(II) The ALC must provide each unit with a means for each member resident to control the temperature in the individual living unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the resident and that preserves resident privacy, independence and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on

documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(III) For ALCS built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 360 square feet.

(IV) The ALC shall provide a private bathroom for each living unit which must be equipped with one lavatory, one toilet, and one bathtub or shower stall.

(V) The ALC must provide at a minimum a kitchenette, defined as a space containing a refrigerator, cooking appliance (microwave is acceptable), and adequate storage space for utensils.

(VI) The member is responsible for furnishing their rental unit. If a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can and lamp, or if the member supplied furnishings pose a health or safety risk, the member's Case Manager in coordination with the ALC must assist the member in obtaining basic furnishings for the unit.

(VII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, the state and local sanitary codes, state building and fire safety codes and laws and regulations governing use and access by persons with disabilities.

(VIII) The ALC must ensure the design of common areas accommodates the special needs of their resident population and that the residential unit accommodates the special needs of the individual in compliance with ADA Accessibility Guidelines (28 CFR Part 36 Appendix A).

(IX) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(X) The ALC must provide appropriately monitored outdoor space for resident use.

(ii) Sanitation

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

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

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

(IV) The ALC must provide housekeeping in member units that maintains a safe, clean and sanitary environment.

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

(iii) Health and Safety

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

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

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

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

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

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

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

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

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

(X) The ALC must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.

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

(iv) Staff to resident ratios

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

(II) The ALC must ensure that staffing is sufficient to meet the needs of the ADvantage Program residents in accordance with each individual's ADvantage Service Plan.

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

(v) Staff training and qualifications

(I) The ALC must ensure that all staff have qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by the Oklahoma Department of Health;

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

(vi) Staff supervision

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

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

(vii) Resident rights

(I) The ALC must provide to each member and member's representative, at the time of admission, a copy of the resident statutory rights listed in O.S. 63-1-1918 amended to include additional rights and clarification of rights as listed in the ADvantage Consumer Assurances. A copy of the resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that its staff is familiar with, and observes, the resident rights.

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

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

(viii) Incident reporting

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage Case Manager, to the ADvantage Program AA and to other entities as required by law or regulation.

(II) Incidents requiring report by licensed Assisted Living Centers are those defined by the Oklahoma State Department of Health (OSDH) in OAC 310:663-19-1.

(III) Reports of incidents must be made to the member's ADvantage Case Manager via facsimile or by telephone within one business day of the reportable incident's discovery. A follow-up report of the incident must be submitted via facsimile or mail to

the member's ADvantage Case Manager within five business days after the incident. The final report must be filed with the member's ADvantage Case Manager and to the ADvantage Administration when the full investigation is complete not to exceed ten business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either the Oklahoma Department of Human Services, the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred or the local municipal police department or sheriff's department as soon as the person is aware of the situation, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes. Reports should also be made to the OSDH, as appropriate, in accordance with the ALC's licensure rules.

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

(ix) Provision of or arrangement for necessary health services

(I) The ALC must arrange or coordinate transportation for members to and from medical appointments.

(II) The ALC must provide or coordinate with the member and the member's ADvantage Case Manager for delivery of necessary health services. The ADvantage Case Manager is responsible for monitoring that all health-related services required by the member as identified through assessment and

documented on the service plan are provided in an appropriate and timely manner.

(E) Assisted Living Services are billed per diem of service for days covered by the ADvantage member's service plan and during which the Assisted Living Services provider is responsible for providing Assisted Living serviced as needed by the member. The per diem rate for the ADvantage assisted living services for a member will be one of three per diem rate levels based upon individual member's need for service - type intensity and frequency to address member ADL/IADL and health care needs. The rate level is based upon UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ADvantage program members must be SoonerCare eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage Assisted Living Center. The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21

and 65, not have mental retardation or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet the following criteria:

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see OAC 317:35-17-3(d)]; and

(C) meet program eligibility criteria [see OAC 317:35-17-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap.

(c) Services provided through the ADvantage waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy/occupational therapy/~~respiratory therapy/~~speech therapy or consultation;

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

(11) medically necessary prescription drugs within the limits of the waiver;

(12) personal care (state plan) or ADvantage personal care;

(13) Personal Emergency Response System (PERS);

(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);

(15) Institution Transition Services;

(16) assisted living; and

(17) SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

(d) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the individual. If the OKDHS/ASD determines all ADvantage waiver slots are filled, the individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the individual's name is placed on a waiting list for entry as an open slot becomes available. ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for persons that have a developmental disability and those that do not have a developmental disability.

(2) the individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have mental retardation or a cognitive impairment.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(e) The OKDHS/ASD determines ADvantage program eligibility through the service plan approval process. The following criteria are used to make the ADvantage program eligibility determination that an individual is not eligible:

(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver individual's health, safety, or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan
services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require ADvantage services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual's health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OKDHS/ASD.

(f) The case manager provides the OKDHS/ASD with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the OKDHS/ASD will provide technical assistance to the Provider for transitioning the individual to other services.

(g) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.