Oklahoma Health Care Authority

Medical Advisory Committee Meeting

AGENDA

November 19, 2015
1:00 p.m. – 3:30pm

Charles Ed McFall Board Room

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

II. Public Comments (2 minute limit)

III. MAC Member Comments/Discussion

IV. Action Item: Approval of Minutes of the September 17, 2015 Medical Advisory Committee Meeting

V. Financial Report SFY16 for three months ended September 30, 2015: **Gloria Hudson, Director of General Accounting**

VI. SoonerCare Operations Update: **Marlene Asmussen, Population Care Management Director**

VII. Aged, Blind, and Disabled (ABD) Care Coordination : **Buffy Heater**, **Director Strategic Planning and Reform** – Verbal update

VIII. Legislature Update: **Emily Shipley, Director of Governmental Affairs –** Update on the 2015 interim studies OHCA is tracking.

IX. Health Policy-Proposed Rule Changes: **Demetria Bennett, Policy Development Coordinator**

   I. 15-14A - Advantage Program Medical Eligibility Determination

   II. 15-14B – Medical Providers-Fee for Service

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

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

   I. Meeting schedule for 2016

   II. Election of Chairperson and Vice-Chairperson

XII. Adjourn

Next Meeting
Thursday, January 21, 2016
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

MINUTES of the September 17, 2015 Meeting

Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:00PM and asked for a roll call. Delegates present were Ms. Brinkley, Dr. Crawford, Ms. Felty, Ms. Galloway, Dr. Gastorf, Mr. Jones, Ms. Mays, Dr. McNeill, Dr. Post, Ms. Pratt-Reid, Dr. Rhynes, Dr. Obhrai, Mr. Snyder, and Dr. Walton. Alternates present were Mr. Clay and Mr. Talley providing a quorum. Delegates absent without an alternate present were: Ms. Bierig, Ms. Booten-Hiser, Dr. Cavallaro, Ms. Fritz, Mr. Goforth, Dr. Grogg, Ms. Hastings, Dr. Kirkpatrick, Mr. Patterson, Mr. Rhoades, Ms. Slatton-Hodges, Mr. Tallent, and Dr. Woodward.

Public Comments

There were no public comments.

Member Comments Approval of Minutes

Dr. Gastorf moved that the minutes of the July 16, 2015 meeting be accepted as submitted online. Mr. Talley seconded the motion. The vote to accept was unanimous.

Financial Update

Carrie Evans, Chief Financial Officer , for the Oklahoma Health Care Authority (OHCA), gave the financial report for the state fiscal year 2015, ending June 30, 2015.

SoonerCare Operations Update

Marlene Asmussen, Population Care Management Director, covered the report found in the agenda showing continuing slow growth in enrollment with a slight dip in Insure Oklahoma membership, an area that Ed Long, Director of Communications was targeting. She introduced a new graphical reporting model for provider enrollment and for the HEDIS quality measurements for the treatment of asthma as compared to national trends.

Ms. Asmussen went on to describe the effective growth of the Population Care Unit, detailing the efforts of the three work units: Case Management, Health Management Program, and the Chronic Care Unit. She completed her presentation with a commendation for Cindi Bryan, RN for her recognition by the Great 100 Nurses of Oklahoma.

State Fiscal Year 2016 Budget Report

Vickie Kersey, Director of Fiscal Planning & Procurement for the agency, presented highlights of the SFY-16 budget and fielded questions. She noted some of the differences between the SFY-16 and the SFY-15 budgets. Budgeted expenditures for Other Practioners, which included a reduced reimbursement rate for polycarbonate lenses. Dr. Rhynes expressed concerns about the amount of the reduction as an impact on the state's optometrists who were already bearing a 7.5% rate reduction from the previous year. Ms. Evans noted that the $4.1M reduction included federal matching funds along with the $1M cut initially discussed by the MAC. Dr. Walton pointed out that the providers were still feeling the full amount of the reduction.

Dr. McNeill asked for clarification on the small portion of the budget attributed to Mid-Level Practioners. Dr. Crawford and others speculated that fees paid to mid-level practioners were wrapped into other budget categories such as Clinic Services and Hospitals. Mr. Clay asked for and received confirmation that the increase of 13.2% for Medical Supplies involved the new Early Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate for incontinence supplies.

Oklahoma State Innovation Model (OSIM) status update

Isaac Lutz, Office of Health Innovation Planning Manager for the Oklahoma State Department of Health, reviewed the mid-grant period status of the OSIM Project. He highlighted the work being done in eight focus areas, all with the "triple-aim" goal of improving health outcomes and quality of care while reducing expenditures. He identified the stakeholders who have participated in the project and the three models currently being studied: Patient Centered Medical Homes, Accountable Care Organizations, and Care Coordination Organizations, each with its own set of advantages and disadvantages. One of the challenges Mr. Lutz identified was identifying the value-based purchasing models that target a minimum of 8% of the payment rate based on quality of service, not just the fee-for-service rendered. The social determinants of health are another challenge that each model addressed differently.

Dr. Walton asked about the input of psychologists in addressing the integration of behavioral health into the models and was told that the project was open to any input from psychologists to augment what the Department of Mental Health and Substance Abuse Services was already contributing.

Dr. Gastorf contrasted the impact of tribal smoke shops with the participation of the Tribal Nations as stakeholders in the project.

ABD Care Coordination House Bill 1566 Mandate Update

Buffy Heater, Director of Strategic Planning and Reform, recapped the latest information about the Request for Information (RFI) on Aged, Blind, and Disabled (ABD) Care Coordination as a prelude to the Request for Proposals (RFP) ordered in HB 1566. She noted a high level of participation in the RFI process with 500 stakeholders attending monthly meetings which are slated to continue at regional sites in a few days. She encouraged the committee to keep up on the progress of the RFP on the agency's website: www.okhca.org/ABDcareCoordination.

Dr. Crawford posited a potential conflict between the goals of the OSIM models and the ABD Care Coordination models and suggested that ABD Care Coordination could be an administrative headache for Oklahoma's providers.

Mr. Snyder asked if the acceptance of RFPs would be predicated on cost savings. Ms. Heater said that the primary goal of the process was to add value to members and outcomes. She noted that the legislature had an expectation of saving money through the process.

Ms. Brinkley echoed Ms. Heater's invitation to participate in the stakeholder meetings. She added that the improvement of care and care coordination was critical to change behaviors, the arena where the long-term savings will be found.

Informational Items

Demetria Bennett, Policy Development Coordinator for the agency, explained that the proposed policy change involving conflict-free care coordination could be studied and commented upon at our public website at: http://www.okhca.org/ProposedPolicyChanges.

Dr. Walton asked what conflict-free care coordination was. Tywanda Cox, Health Policy Director, explained that it meant that the writer of a treatment plan could not also bill for the services in the treatment plan and noted that this is already practiced, but that the policy needed to reflect that.

New Business/Member Comments

No new business.

Adjournment

There being no new business, Dr. Crawford asked for a motion to adjourn. It was provided by Mr. Snyder and seconded by Dr. Walton. The meeting ended at 2:40 PM.

FINANCIAL REPORT

For the Three Months Ended September 30, 2015
Submitted to the CEO & Board

- Revenues for OHCA through September, accounting for receivables, were **$1,050,162,983** or **1.9% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,000,486,361 or 2.7% under** budget.
- The state dollar budget variance through September is a **positive $8,380,104.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		7.7
Administration		.8
Revenues:		
Drug Rebate		(0.1)
Taxes and Fees		1.1
Overpayments/Settlements		(1.1)
Total FY 15 Variance	**$**	**8.4**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2016, For the Three Month Period Ending September 30, 2015

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 9,711,256	$ 9,673,567	$ -	$ 34,638	$ -	$ 3,051	$ -
Inpatient Acute Care	313,793,601	157,466,498	121,672	1,064,483	83,225,354	486,670	71,428,926
Outpatient Acute Care	99,706,303	75,364,007	10,401	1,055,562	22,465,442	810,891	
Behavioral Health - Inpatient	12,690,217	3,136,022	-	82,396	6,265,547	-	3,206,253
Behavioral Health - Psychiatrist	2,511,993	2,119,780	-	-	392,213	-	-
Behavioral Health - Outpatient	7,477,674	-	-	-	-	-	7,477,674
Behaviorial Health-Health Home	5,257,002	-	-	-	-	-	5,257,002
Behavioral Health Facility- Rehab	61,875,590	-	-	-	-	18,498	61,875,590
Behavioral Health - Case Management	4,800,009	-	-	-	-	-	4,800,009
Behavioral Health - PRTF	21,918,007	-	-	-	-	-	21,918,007
Residential Behavioral Management	5,365,975	-	-	-	-	-	5,365,975
Targeted Case Management	16,845,616	-	-	-	-	-	16,845,616
Therapeutic Foster Care	345,379	345,379	-	-	-	-	-
Physicians	138,131,332	120,634,800	14,525	787,193	-	1,429,615	15,265,198
Dentists	35,499,879	35,494,685	-	1,548	-	3,646	-
Mid Level Practitioners	675,477	671,556	-	3,787	-	134	-
Other Practitioners	11,131,252	10,995,986	111,591	22,434	-	1,240	-
Home Health Care	5,317,184	5,312,795	-	1,441	-	2,948	-
Lab & Radiology	17,212,663	16,747,859	-	376,886	-	87,917	-
Medical Supplies	11,387,901	10,635,046	677,884	64,991	-	9,981	-
Clinic Services	32,481,406	30,058,384	-	174,374	-	44,721	2,203,927
Ambulatory Surgery Centers	1,876,037	1,834,822	-	37,641	-	3,574	-
Personal Care Services	3,471,154	-	-	-	-	-	3,471,154
Nursing Facilities	149,717,512	94,852,140	54,862,258	-	-	3,113	-
Transportation	17,026,481	16,357,293	657,765	-	-	11,423	-
GME/IME/DME	35,215,869	-	-	-	-	-	35,215,869
ICF/IID Private	16,046,252	13,089,088	2,957,164	-	-	-	-
ICF/IID Public	2,523,966	-	-	-	-	-	2,523,966
CMS Payments	53,813,842	53,626,963	186,880	-	-	-	
Prescription Drugs	132,644,784	129,603,576	-	2,572,173	-	469,035	-
Miscellaneous Medical Payments	34,967	34,813	-	-	-	154	-
Home and Community Based Waiver	52,399,045	-	-	-	-	-	52,399,045
Homeward Bound Waiver	23,229,351	-	-	-	-	-	23,229,351
Money Follows the Person	2,044,954	140,995	-	-	-	-	1,903,960
In-Home Support Waiver	6,913,532	-	-	-	-	-	6,913,532
ADvantage Waiver	48,096,093	-	-	-	-	-	48,096,093
Family Planning/Family Planning Waiver	1,773,758	-	-	-	-	-	1,773,758
Premium Assistance*	11,305,055	-	-	11,305,055	-	-	-
Electronic Health Records Incentive Payments	3,416,737	3,416,737	-	-	-	-	-
Total Medicaid Expenditures	**$ 1,375,685,102**	**$ 791,612,789**	**$ 59,600,140**	**$ 17,584,601**	**$ 112,348,556**	**$ 3,386,612**	**$ 391,170,902**

* Includes $11,227,399 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2016, For the Three Month Period Ending September 30, 2015

		FY16 Actual YTD
REVENUE		
Revenues from Other State Agencies		$ 160,987,569
Federal Funds		242,916,151
TOTAL REVENUES		**$ 403,903,720**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$ 52,399,045	$ 52,399,045
Money Follows the Person	1,903,960	1,903,960
Homeward Bound Waiver	23,229,351	23,229,351
In-Home Support Waivers	6,913,532	6,913,532
ADvantage Waiver	48,096,093	48,096,093
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	2,523,966	2,523,966
Personal Care	3,471,154	3,471,154
Residential Behavioral Management	4,138,365	4,138,365
Targeted Case Management	13,906,012	13,906,012
Total Department of Human Services	**156,581,476**	**156,581,476**
State Employees Physician Payment		
Physician Payments	15,427,209	15,427,209
Total State Employees Physician Payment	**15,427,209**	**15,427,209**
Education Payments		
Graduate Medical Education	2,003,058	2,003,058
Graduate Medical Education - Physicians Manpower Training Commission	964,495	964,495
Indirect Medical Education	32,248,316	32,248,316
Direct Medical Education	-	-
Total Education Payments	**35,215,869**	**35,215,869**
Office of Juvenile Affairs		
Targeted Case Management	812,381	812,381
Residential Behavioral Management	1,227,610	1,227,610
Total Office of Juvenile Affairs	**2,039,991**	**2,039,991**
Department of Mental Health		
Case Management	4,800,009	4,800,009
Inpatient Psychiatric Free-standing	3,206,253	3,206,253
Outpatient	7,477,674	7,477,674
Health Homes	4,701,981	4,701,981
Psychiatric Residential Treatment Facility	21,918,007	21,918,007
Rehabilitation Centers	61,880,509	61,880,509
Total Department of Mental Health	**103,984,432**	**103,984,432**
State Department of Health		
Children's First	414,276	414,276
Sooner Start	543,237	543,237
Early Intervention	1,332,428	1,332,428
Early and Periodic Screening, Diagnosis, and Treatment Clinic	466,851	466,851
Family Planning	(6,826)	(6,826)
Family Planning Waiver	1,518,667	1,518,667
Maternity Clinic	2,812	2,812
Total Department of Health	**4,271,445**	**4,271,445**
County Health Departments		
EPSDT Clinic	174,760	174,760
Family Planning Waiver	2,088	2,088
Total County Health Departments	**176,848**	**176,848**
State Department of Education	**47,722**	**47,722**
Public Schools	**276,998**	**276,998**
Medicare DRG Limit	**70,000,000**	**70,000,000**
Native American Tribal Agreements	**462,649**	**462,649**
Department of Corrections	**423,826**	**423,826**
JD McCarty	**1,005,099**	**1,005,099**
Total OSA Medicaid Programs	**$ 389,913,565**	**$ 389,913,565**
OSA Non-Medicaid Programs	**$ 18,517,104**	**$ 18,517,104**
Accounts Receivable from OSA		**$ 4,526,950**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2016, For the Three Month Period Ending September 30, 2015

REVENUES	FY 16 Revenue
SHOPP Assessment Fee	$ 50,260,367
Federal Draws	69,993,150
Interest	34,078
Penalties	44,651
State Appropriations	(7,550,000)
TOTAL REVENUES	$ 112,782,245

EXPENDITURES	Quarter	FY 16 Expenditures
Program Costs:	7/1/15 - 9/30/15	
Hospital - Inpatient Care	83,225,354	$ 83,225,354
Hospital -Outpatient Care	22,465,442	$ 22,465,442
Psychiatric Facilities-Inpatient	6,265,547	$ 6,265,547
Rehabilitation Facilities-Inpatient	392,213	$ 392,213
Total OHCA Program Costs	112,348,555	$ 112,348,555
Total Expenditures		$ 112,348,555

CASH BALANCE	$ 433,690

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2016, For the Three Month Period Ending September 30, 2015

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 18,781,831	$ 18,781,831
Interest Earned	9,097	9,097
TOTAL REVENUES	**$ 18,790,928**	**$ 18,790,928**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 53,949,666	$ 20,339,024	
Eyeglasses and Dentures	71,213	26,847	
Personal Allowance Increase	841,380	317,200	
Coverage for Durable Medical Equipment and Supplies	677,883	255,562	
Coverage of Qualified Medicare Beneficiary	258,189	97,337	
Part D Phase-In	186,880	186,880	
ICF/IID Rate Adjustment	1,359,542	512,547	
Acute Services ICF/IID	1,597,623	602,304	
Non-emergency Transportation - Soonerride	657,765	247,977	
Total Program Costs	**$ 59,600,139**	**$ 22,585,679**	**$ 22,585,679**
Administration			
OHCA Administration Costs	$ 131,316	$ 65,658	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 131,316**	**$ 65,658**	**$ 65,658**
Total Quality of Care Fee Costs	**$ 59,731,455**	**$ 22,651,337**	
TOTAL STATE SHARE OF COSTS			**$ 22,651,337**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2016, For the Three Month Period Ending September 30, 2015

REVENUES	FY 15 Carryover	FY 16 Revenue	Total Revenue
Prior Year Balance	$ 27,746,235	$ -	$ 1,391,011
State Appropriations	(25,000,000)	-	-
Tobacco Tax Collections	-	10,609,149	10,609,149
Interest Income	-	68,492	68,492
Federal Draws	127,814	7,322,412	7,322,412
TOTAL REVENUES	$ 2,874,049	$ 18,000,053	$ 19,391,065

EXPENDITURES		FY 15 Expenditures	FY 16 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 11,227,399	$ 11,227,399
	College Students		77,656	27,941
Individual Plan				
	SoonerCare Choice		$ 33,198	$ 11,945
	Inpatient Hospital		1,064,483	383,001
	Outpatient Hospital		1,038,891	373,793
	BH - Inpatient Services-DRG		80,665	29,023
	BH -Psychiatrist		-	-
	Physicians		776,305	279,314
	Dentists		855	308
	Mid Level Practitioner		3,784	1,361
	Other Practitioners		22,160	7,973
	Home Health		1,441	518
	Lab and Radiology		371,718	133,744
	Medical Supplies		61,518	22,134
	Clinic Services		171,670	61,767
	Ambulatory Surgery Center		37,641	13,543
	Prescription Drugs		2,528,192	909,643
	Miscellaneous Medical		-	-
	Premiums Collected		-	(94,995)
Total Individual Plan			$ 6,192,520	$ 2,133,073
	College Students-Service Costs		$ 87,026	$ 31,312
Total OHCA Program Costs			$ 17,584,601	$ 13,419,725
Administrative Costs				
	Salaries	$ 73,467	$ 520,675	$ 594,142
	Operating Costs	60,069	213,429	273,498
	Health Dept-Postponing	-	-	-
	Contract - HP	1,349,503	911,030	2,260,533
Total Administrative Costs		$ 1,483,038	$ 1,645,134	$ 3,128,172
Total Expenditures				$ 16,547,897
NET CASH BALANCE		$ 1,391,011		$ 2,843,167

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2016, For the Three Month Period Ending September 30, 2015

REVENUES	FY 16 Revenue	State Share
Tobacco Tax Collections	$ 211,663	$ 211,663
TOTAL REVENUES	**$ 211,663**	**$ 211,663**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 3,051	$ 805	
Inpatient Hospital	486,670	128,432	
Outpatient Hospital	810,891	213,994	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	3,113	821	
Physicians	1,429,615	377,275	
Dentists	3,646	962	
Mid-level Practitioner	134	35	
Other Practitioners	1,240	327	
Home Health	2,948	778	
Lab & Radiology	87,917	23,201	
Medical Supplies	9,981	2,634	
Clinic Services	44,721	11,802	
Ambulatory Surgery Center	3,574	943	
Prescription Drugs	469,035	123,778	
Transportation	11,423	3,015	
Miscellaneous Medical	154	41	
Total OHCA Program Costs	$ 3,368,114	$ 888,845	
OSA DMHSAS Rehab	$ 18,498	$ 4,882	
Total Medicaid Program Costs	$ 3,386,612	$ 893,727	
TOTAL STATE SHARE OF COSTS			**$ 893,727**

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.

SoonerCare Operations Report

OHCA Board Meeting - November 12, 2015 (September 2015 Data)

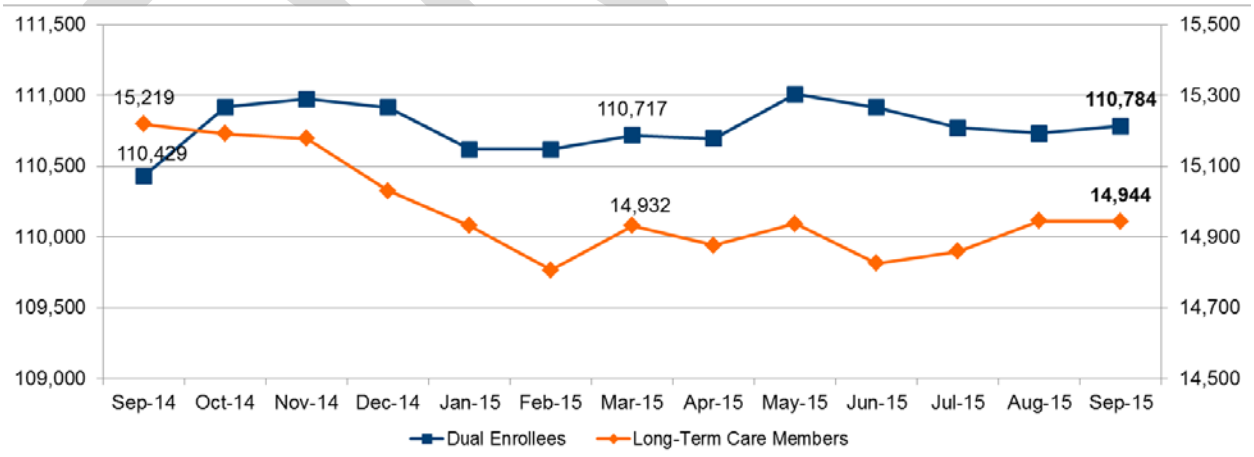
SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment September 2015	Children September 2015	Adults September 2015	Enrollment Change	Total Expenditures Sep 2015	PMPM September 2015	Forecasted Sep 2015 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**540,708**	**444,368**	**96,340**	**-4,394**	**$157,171,788**		
	Lower Cost	*(Children/Parents; Other)*	496,457	430,236	66,221	-4,091	$108,064,149	$218	$216
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	44,251	14,132	30,119	-303	$49,107,639	$1,110	$956
SoonerCare Traditional			**238,083**	**92,065**	**146,018**	**-2,124**	**$219,945,503**		
	Lower Cost	*(Children/Parents; Other)*	127,152	87,007	40,145	-2,337	$62,344,934	$490	$391
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	110,931	5,058	105,873	213	$157,600,569	$1,421	$1,291
SoonerPlan			**40,173**	**2,998**	**37,175**	**-1,636**	**$447,575**	$11	$8
Insure Oklahoma			**17,098**	**477**	**16,621**	**-40**	**$5,789,245**		
	Employer-Sponsored Insurance		13,117	310	12,807	32	$3,614,036	$276	$278
	Individual Plan		3,981	167	3,814	-72	$2,175,209	$546	$483
TOTAL			**836,062**	**539,908**	**296,154**	**-8,194**	**$383,354,110**		

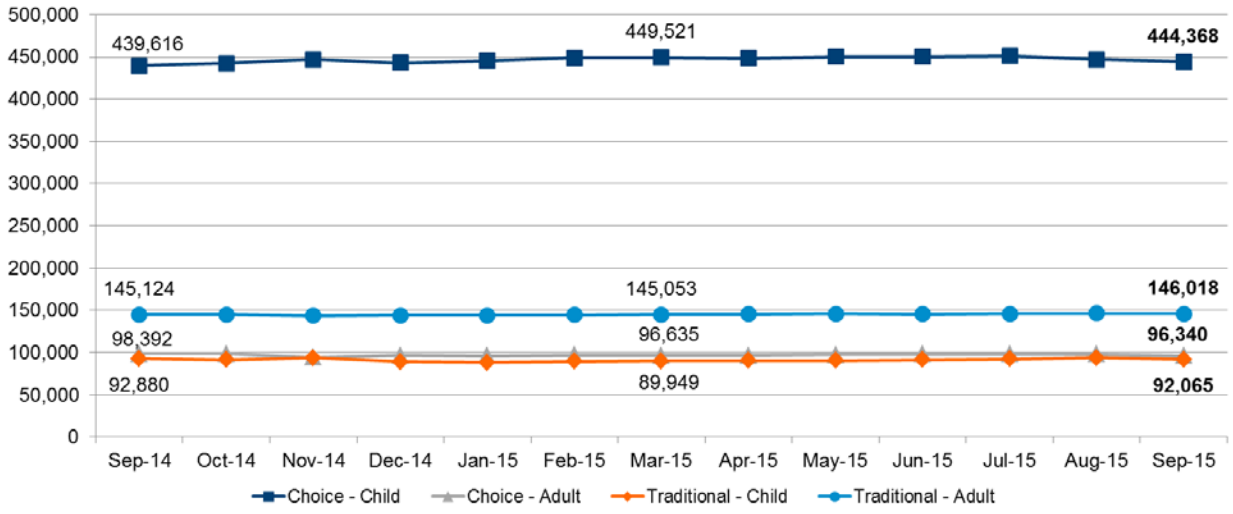
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

Total In-State Providers		33,449	(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)					
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,646	936	1,203	197	5,230	635	240	6,543	2,478

DUAL ENROLLEES & LONG-TERM CARE MEMBERS



CHILDREN & ADULTS ENROLLMENT



HEDIS QUALITY MEASURES - COMPREHENSIVE DIABETES CARE (CDC)

The following 3 measures cover the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: 1) Hemoglobin A1c (HbA1c) testing; 2) Eye Exam (retinal); and 3) Medical attention for nephropathy.

The eligible population was members who were 18-75 years of age during the measurement year and were not enrolled in any Home & Community Based Waiver during the measurement year. Members were continuously enrolled during the measurement period with a gap in enrollment of up to 45 days allowed.

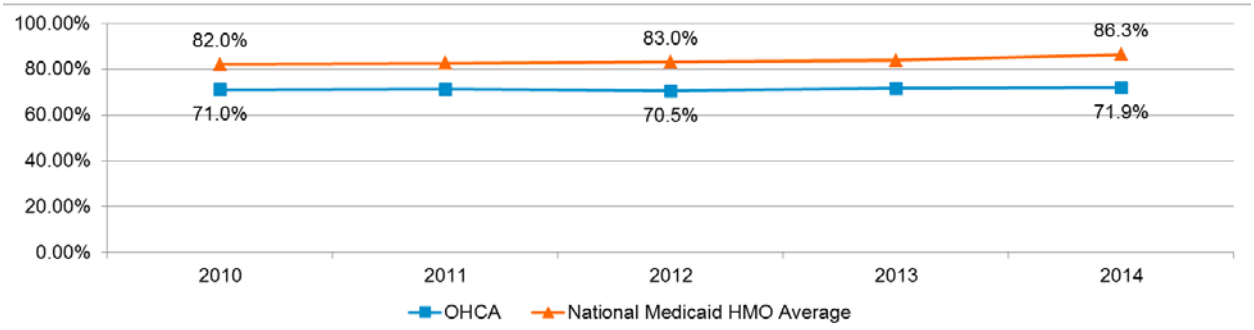
Members with diabetes were identified in one of three ways using claims data for the measurement year and/or the year prior to the measurement year:

1) At least two outpatient visits, observation visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes.

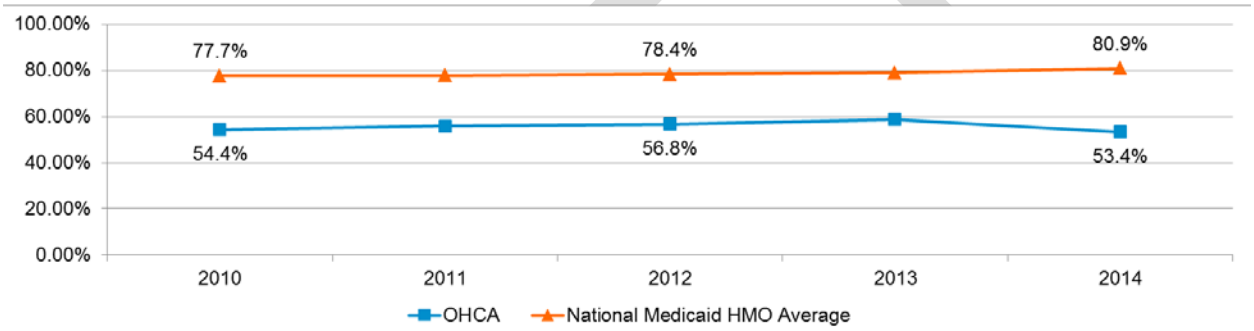
2) At least one acute inpatient encounter or ED visit with a diagnosis of diabetes.

3) At least one pharmacy claim where members were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis.

HEDIS QUALITY MEASURE - CDC - HEMOGLOBIN A1C TESTING

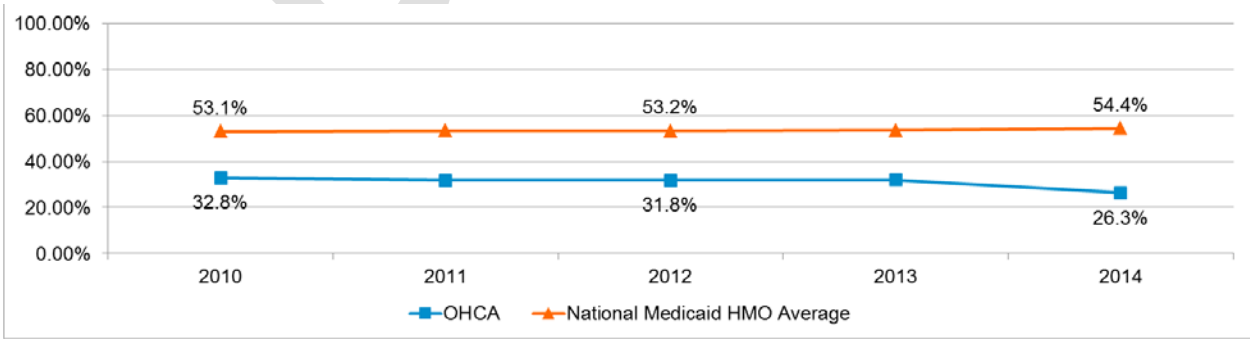


HEDIS QUALITY MEASURE - CDC - MEDICAL ATTENTION FOR NEPHROPATHY



HEDIS QUALITY MEASURE - CDC - EYE EXAM (RETINAL)

Member of eligible population had an eye screening for diabetic retinal disease during the measurement year. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year; or A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.



Proposed Policy Changes

November MAC
Proposed Rule Amendment Summaries

Face to face tribal consultations regarding the following proposed changes were held Tuesday, September 1, 2015 in the Board Room of the OHCA.

The following rules are posted for comment from October 16, 2015 through November 15, 2015.

15-14A&B Conflict free case management — The Department of Human Services policy is being revised to comply with federal regulation. The proposed changes adhere to the CMS conflict free case management requirements and Home and Community Based settings requirements for Medicaid Assisted Living Programs that are directly related to the Assisted Living Service Option in ADvantage program.
Budget Impact: Budget neutral

15-14A

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. ADVANTAGE PROGRAM MEDICAL ELIGIBILITY DETERMINATION
SUBCHAPTER 1. ADVANTAGE WAIVER SERVICES

317:35-17-5. ADvantage program medical eligibility determination

The ~~OKDHS~~Oklahoma Department of Human Services(DHS) area nurse, or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT)Parts I~~, Part~~ and III, and other ~~available~~ medical information.

(1) When ADvantage care services are requested or the UCAT I is received in the county office, the:

(A) ~~the OKDHS~~DHS nurse is responsible for completing the UCAT III~~.~~;and

(B) ~~the~~ social ~~worker~~service specialist is responsible for contacting the ~~individual~~applicant within three ~~working~~business days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. If a categorical relationship to disability ~~has~~was not ~~already been~~ established, the local social ~~worker~~service specialist submits the same information ~~described in OAC~~per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship to the ~~disabled~~person with the disability using the ~~same definition used by SSA~~Social Security Administration (SSA) definition. A follow-up is required by the ~~OKDHS~~DHS social ~~worker~~service specialist with ~~the Social Security Administration~~SSA to ~~be sure their~~ensure the disability decision agrees with the LOCEU decision ~~of LOCEU~~.

(3) Community agencies complete the UCAT~~, Part~~ I, and ~~forwards~~forward the form to the county office. ~~If~~When the UCAT~~, Part~~ I indicates ~~that~~ the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources. Members may also call the care line at 800-435-4711.

(4) The ~~OKDHS~~DHS nurse ~~completes the UCAT, Part III assessment visit~~visits with the member within 10 ~~working~~business days of receipt of the referral for ADvantage services for ~~a client~~an applicant who is Medicaid eligible at the time of the request. The ~~OKDHS~~DHS nurse completes the UCAT~~, Part~~ III assessment within 20 ~~working~~business days of

the date the Medicaid application is completed for new applicants.

(5) During the assessment visit, the ~~OKDHS~~DHS nurse informs the applicant of medical eligibility and provides information about the different long-term care service options. ~~If~~When there are multiple household members applying for the ADvantage program, the UCAT assessment is done for ~~the applicant household members~~them during the same visit. The ~~OKDHS~~DHS nurse documents whether the member chooses ~~NF~~nursing facility program services or ADvantage program services~~. In addition, the OKDHS nurse~~and makes a level of care and service program recommendation.

(6) The ~~OKDHS~~DHS nurse informs the member and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the ~~client's~~applicant's primary and secondary informed choices~~.~~, ensuring adherence to conflict free case management requirements

(A) ~~If the member and/or family declines to make a provider choice, the OKDHS nurse documents that decision on the member choice form.~~Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services.

(B) ~~The AA uses a rotating system to select an agency for the member from a list of all local certified case management and in-home care agencies.~~If the member and/or family declines to make a provider choice, the DHS nurse documents the decision on Form 02CB001, Member Consents and Rights.

(C) The AA uses a rotating system to select an agency for the member from a list of all local, certified case management and in-home care agencies, ensuring adherence to conflict free case management requirements.

(7) The ~~OKDHS~~DHS nurse documents the names of the chosen agencies and the agreement ~~(by dated signature)~~ of the member, by dated signature, to receive services provided by the agencies.

(8) ~~If~~When the ~~needs of the member~~member's needs require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the ~~OKDHS~~DHS nurse documents the need for

priority processing.
(9) The ~~OKDHS~~DHS nurse scores the UCAT, Part III. The ~~OKDHS~~DHS nurse forwards the UCAT, Parts I and III, documentation of financial eligibility, ~~and~~ documentation of the member's case management and in-home care agency choices to the area nurse, or nurse designee, for medical eligibility determination.
(10) If, based upon the information obtained during the assessment, the ~~OKDHS~~DHS nurse determines ~~that~~ the member may be at risk for health and safety, ~~OKDHS~~DHS Adult Protective Services ~~(APS)~~ staff ~~are~~is notified immediately and the referral is documented on the UCAT.
(11) Within ~~ten working~~10 business days of receipt of a complete ADvantage application, the area nurse~~,~~ or nurse designee, determines medical eligibility using ~~NF~~nursing facility level of care criteria and service eligibility criteria ~~[refer to~~per OAC 317:35-17-2 and ~~OAC~~ 317:35-17-3~~]~~ and enters the medical decision on the system.
(12) Upon notification of financial eligibility from the social ~~worker~~service specialist, medical eligibility ~~(MS-52~~), and approval for ADvantage entry from the area nurse~~,~~ or nurse designee, the AA communicates with the case management provider to begin care ~~plan~~ and service plan development. The AA communicates to the ~~client's~~ case management provider, the member's name, address, case number, ~~and social security~~Social Security number, the number of units of case management and, ~~if~~when applicable, the number of units of home health agency nurse evaluation authorized for ~~care plan and~~ service plan development. ~~If~~When the member requires an immediate home visit to develop a service plan within 24 hours, the AA contacts the case management provider directly to confirm availability and ~~then~~ sends the new case packet information to the case management provider via ~~facsimile~~email.
(13) ~~If~~When the services must be in place to ensure the health and safety of the member upon discharge to the home from the ~~NF~~nursing facility or ~~Hospital~~hospital, a ~~nurse~~ case manager from an ADvantage case management provider selected by the ~~client~~member and referred by the AA follows the ADvantage ~~Institution Transition~~institution transition, case management procedures for care ~~plan~~ and service plan development and implementation.
(14) A new medical level of care determination is required when a member requests any ~~of the following~~ changes in service program, from:
(A) ~~from~~ State Plan Personal Care to ADvantage services~~.~~;
(B) ~~from~~ ADvantage to State Plan Personal Care services~~.~~;

(C) ~~from Nursing Facility~~nursing facility to ADvantage services~~.~~; or

(D) ~~from~~ ADvantage to ~~Nursing Facility~~nursing facility services.

(15) A new medical level of care determination is not required when a member requests re-activation of ADvantage services after a short-term stay ~~(~~of 90 calendar-days or less~~)~~ in a ~~Nursing~~ ~~Facility~~nursing facility when the member has had previous ADvantage services and the ADvantage certification period has not expired.

(16) When a UCAT assessment ~~has been~~was completed more than 90 calendar-days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

15-14B

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are ~~as follows~~:

(1) **Case ~~Management~~management.**

(A) Case ~~Management~~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~~Waiver program eligibility. Case managers develop the member's comprehensive service plan ~~of care~~, listing only services ~~which are~~ necessary to prevent institutionalization of the member, as determined through the 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 service plan ~~of care~~ reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. ~~If~~When 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~~managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal

Assistance Services and Supports (CD-PASS), ~~Case Managers~~case manager supervisors and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate ~~competency in Person-centered planning~~ person-centered planning competency.

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

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

(ii) ~~Ancillary~~ancillary activities, such as clerical tasks ~~like~~including, but not limited to, mailing, copying, filing, faxing, ~~drive~~driving time, or supervisory~~/~~and administrative activities that are not billable case management activities~~, and although the~~. The administrative cost of these activities and other normal and customary business overhead costs ~~have been~~are included in the reimbursement rate for billable activities.

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

(ii) Very ~~Rural/Difficult Service Area Rate~~rural/difficult service area rate: Case ~~Management~~management services are billed using a ~~Very Rural/Difficult Service Area~~very rural/difficult service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than 25 persons per square mile. ~~An exception would be~~Exceptions are services to members ~~that~~who reside in Oklahoma Department of Human Services~~/~~ Aging Services ~~Division (OKDHS/ASD)~~(DHS AS) identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the ~~Standard~~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~~Services are provided on a short-term basis ~~because of~~due to the primary caregiver's 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~~is only ~~be~~ utilized when other sources of care and support ~~have been~~are exhausted. Respite care ~~will~~is only ~~be~~ listed on the service 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 service plan ~~of care~~.

(B) ~~In-Home Respite~~In-home respite services are billed per 15-minute ~~unit~~units of 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~~Facility-based extended respite is filed for a per diem rate ~~if~~when provided in ~~Nursing Facility~~a nursing facility. Extended ~~Respite~~respite must be at least eight hours in duration.

(D) ~~In-Home Extended Respite~~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~~ day health care.**

(A) Adult ~~Day Health Care~~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 member's optimal functioning ~~of the member~~. Physical, occupational, and~~/or~~ speech therapies ~~may~~are only ~~be~~ provided as an enhancement to the basic ~~Adult Day Health Care~~adult day health care service when authorized by the service plan ~~of care~~ and are billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Personal ~~Care~~care service enhancement in ~~Adult Day Health Care~~adult day health care is assistance in bathing, ~~and/or~~ hair ~~washing~~care, or laundry service, authorized by the service plan ~~of care~~ and billed as ~~a~~ separate ~~procedure~~procedures. Most assistance with activities of daily living (ADL), such as eating, mobility, toileting, and nail care~~,~~ are ~~services that are~~ integral services to ~~the Adult Day Health Care~~adult day health care service and are covered by the ~~Adult Day Health Care~~adult day health care basic reimbursement rate. Assistance with bathing, hair care, or laundry service is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing, hair care, or laundry ~~will be~~service is authorized when an ADvantage ~~waiver~~Waiver member who uses adult day health

care requires assistance with bathing, hair care, or laundry service to maintain his or her health and safety.
(B) Adult ~~Day Health Care~~day health care is a 15-minute unit of service. No more than ~~8~~eight hours, ~~(~~32 units~~)~~, are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan ~~of care~~.
(C) Adult ~~Day Health Care Therapy Enhancement~~day health care therapy enhancement is a maximum of one session unit per day ~~unit~~ of service.
(D) Adult ~~Day Health Personal Care Enhancement~~day health personal care enhancement is a maximum of one unit per day ~~unit~~ of bathing, hair care, or laundry service.
(4) **Environmental ~~Modifications~~modifications**.
(A) Environmental ~~Modifications~~modifications are physical adaptations to the home, required by the member's service plan ~~of care, which~~that are necessary to ensure the health, welfare, and safety of the ~~individual~~member~~,~~ or ~~which~~ enable the ~~individual~~member to function with greater independence in the home and that without ~~which~~such, the member would require institutionalization. Adaptations or improvements to the home ~~which are~~ not of direct medical or remedial benefit to the ~~waiver~~Waiver member are excluded.
(B) All services require prior authorization.
(5) **Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies.**
(A) Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies are devices, controls, or appliances specified in the service plan ~~of care, which~~that enable members to increase ~~their abilities~~his or her ability to perform ~~activities of daily living~~ADLs, or to perceive, control, or communicate with the environment in which they live. ~~Also included are items necessary~~Necessary items for life support, ancillary supplies, and equipment necessary ~~to~~for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan are also included. This service excludes any equipment and/or supply items ~~which are~~ not of direct medical or remedial benefit to the ~~waiver~~Waiver member. This service is necessary to prevent institutionalization.
(B) Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies are billed using the appropriate ~~HCPC procedure code~~HealthCare Common Procedure Code (HCPC). Reoccurring supplies ~~which are~~ shipped and delivered to the member are compensable only when the member remains eligible for ~~waiver~~Waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility,

or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the the SoonerCare rate if established, to the Medicare rate, or to actual acquisition cost, plus 30 percent. All services must ~~be~~have prior ~~authorized~~authorization.

(6)**Advanced~~Supportive/Restorative~~Assistance~~supportive/restorative assistance~~**.

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

(B)Advanced~~Supportive/Restorative Assistance~~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 service plan ~~of care~~.

(7) **Nursing.**

(A) Nursing services are services listed in the service plan ~~of care which~~that are within the scope of the Oklahoma Nursing Practice Act. ~~and~~ These services are provided by a registered ~~professional~~ nurse(RN), ~~or~~a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of ~~a registered nurse,~~an RN licensed to practice in the ~~State~~state. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service ~~will work~~works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or ~~preventive~~preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services ~~which would be~~ reimbursable under either Medicaid or ~~Medicare's~~the Medicare Home Health Program. This service primarily provides nurse supervision to the ~~Personal Care Assistant~~personal care assistant or to the ~~Advanced Supportive/Restorative Assistance Aide~~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 service plan ~~of care~~. A nursing assessment/evaluation, on-site visit is made to each member for whom ~~Advanced Supportive/Restorative Assistance~~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~~is made to the ADvantage Program case manager in accordance with review schedule determined ~~in consultation~~ between the ~~Case Manager~~case manager and ~~the Nurse~~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 ~~Nursing~~nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of the:

(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~~ per rules and regulations for the 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 ~~Nursing~~nursing services ~~for the following~~ to:

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

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

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

(IV) ~~providing~~provide nail care for the ~~diabetic~~ member with diabetes or member ~~with~~who has circulatory or neurological compromise;

(V) ~~providing~~provide 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~~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 are also provided.

(C) Nursing service ~~can be billed for~~includes interdisciplinary team planning and recommendations for the member's 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 interdisciplinary team planning and recommendations for the member's service plan and for performing assessment/evaluations, ~~assessment/evaluation/service plan development nursing services and other~~another procedure ~~codesare~~code is used to bill for all other authorized nursing services. A maximum of eight units per day of nursing for ~~assessment /evaluation and/or~~ service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement~~,~~ to provide ~~the 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~~when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled ~~Nursing Services~~nursing services.**

(A) Skilled ~~Nursing Services~~nursing services listed in the service plan ~~of carewhich~~that are within the scope of the ~~State's~~state's Nurse Practice Act and are ordered by a licensed ~~medical~~ physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by ~~a registered professional nurse, or licensed practical or vocational nurse~~an RN, or an LPN or LVN under the supervision of a registered nurse, licensed to practice in the ~~State~~state. Skilled ~~Nursing~~nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage ~~Nursing Services~~nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. ~~It is the responsibility of the RN to contact~~The RN contacts the member's physician to obtain ~~any~~ necessary information or orders pertaining to the member's care ~~of the member~~. ~~If~~When the member has an ongoing need for service activities~~, which require~~requiring more or less units than authorized, the RN ~~shall~~must recommend, in writing, that the ~~Plan of Care~~service plan be revised.

(B) Skilled ~~Nursing~~nursing services are provided on an intermittent or part-time basis, and billed ~~in units of~~ per 15-

minute ~~increments~~units of service. ~~ADvantage~~ Skilled ~~Nursing~~nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services ~~furnished under SoonerCare plan limits~~ are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's service plan.

(9) **Home ~~Delivered Meals~~ delivered meals.**

(A) Home ~~Delivered Meals~~ 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~~ dietary reference intakes 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~~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~~in accordance with the member's service plan ~~of care~~. The provider must obtain a signature from the member or the member's representative at the time the ~~meals are~~meal is delivered. In the event ~~that~~ the member is temporarily unavailable, such as at a ~~(i.e.,~~ doctor's appointment, ~~etc.)~~ and the meal is left at the member's home, the provider must document the reason a signature ~~is~~was not obtained. The signature logs must be available for review.

(10) **Occupational ~~Therapy Services~~therapy services.**

(A) Occupational ~~Therapy~~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 enabling him or her to reside and participate in the community. Treatment involves the therapeutic use of self-care, work, ~~and~~ play activities, and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written, therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the ~~limits~~limitations of ~~their~~his or her practice, working under the supervision of ~~the~~a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services~~, where~~when appropriate.

The occupational therapist ~~will ensure~~ensures monitoring and documentation of the member's rehabilitative progress and ~~will report~~reports to the member's case manager and physician to coordinate the necessary addition ~~and/~~or deletion of services, based on the member's condition and ongoing rehabilitation potential.
(B) Occupational ~~Therapy~~therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.
(11) **Physical ~~Therapy Services~~therapy services.**
(A) Physical ~~Therapy~~therapy services are those services that ~~prevent~~maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the ~~limits~~limitations of ~~their~~his or her 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~~when appropriate. The licensed physical therapist ~~will ensure~~ensures monitoring and documentation of the member's rehabilitative progress and ~~will report~~reports to the member's case manager and physician to coordinate the necessary addition ~~and/~~or deletion of services, based on the member's condition and ongoing rehabilitation potential.
(B) Physical ~~Therapy~~therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.
(12) **Speech and ~~Language Therapy Services~~language therapy services.**
(A) Speech~~/Language Therapy~~and language therapy services are those that ~~prevent~~maintain or improve 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 the 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~~speech and 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~~limitations of ~~their~~his or her practice, working under the supervision of the licensed ~~Speech/Language Pathologist~~speech and language pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services~~, where~~when appropriate. The ~~Pathologist will ensure~~speech and language pathologist ensures monitoring and documentation of the member's rehabilitative progress and ~~will report~~reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

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

(A) Hospice ~~is~~services are palliative and~~/or~~ comfort care provided to the member and ~~his/her~~his or her family when a physician certifies ~~that~~ the member has a terminal illness, ~~and has six months or less to live~~with a life expectancy of six months or less, and orders hospice care. ADvantage ~~Hospice Care~~hospice care is authorized for a six-month period, and requires ~~a~~ physician certification of a terminal illness and orders of hospice care. ~~If~~When 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~~30-calendar 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~~hospice may be authorized for a maximum of 60-calendar 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~~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~~through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care ~~that has~~with the objective to treat and cure the member's illness. Once the member has

elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the ~~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~~therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's 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. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.~~

(C) 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 member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.~~(C)~~(D) Hospice services are billed per diem of service for days covered by a ~~Hospice~~hospice plan of care and ~~during which~~while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's ~~Hospice~~hospice care within a ~~twelve~~ 12-month period is limited to an amount equivalent to 85~~%~~percent of the Medicare ~~Hospice Cap~~hospice cap payment, and must be authorized on the member's service plan.

(14) **ADvantage ~~Personal Care~~ personal care.**

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

(B) ADvantage ~~Home Care Agency Skilled Nursing~~home care agency skilled nursing staff working in coordination with an ADvantage ~~Case Manager~~case manager are responsible for the development and monitoring of the member's ~~Personal Care plan~~personal care services.
(C) ADvantage ~~Personal Care~~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 service plan ~~of care~~.
(15) **Personal ~~Emergency Response System~~emergency response system.**
(A) Personal ~~Emergency Response System~~emergency response system (PERS) is an electronic device ~~which~~that enables ~~certain individuals~~members at high risk of institutionalization, to secure help in an emergency. ~~The individual~~Members may also wear a portable "help" button to allow for mobility. ~~The system~~PERS is connected to the person's phone and programmed to signal, ~~in accordance with~~per member preference, a friend, ~~a~~ relative, or a response center, once ~~a~~the "help" button is activated. ~~The response center is staffed by trained professionals.~~ For an ADvantage ~~Program~~ member to be eligible ~~to receive~~ for PERS service, the member must meet all of the ~~following~~ service criteria~~:~~ in (i) through (vi). The
(i) member has a recent history of falls as a result of an existing medical condition that prevents the ~~individual~~member from getting up unassisted from a fall ~~unassisted~~;
(ii) member lives alone and ~~has no~~without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
(iii) member demonstrates the capability to comprehend the purpose of~~,~~ and activate the PERS;
(iv) member has a health and safety plan detailing the interventions beyond the PERS to ~~assure~~ensure the member's health and safety in ~~his/her~~his or her home;
(v) member 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 PERS purchase ~~of PERS~~. All services are prior-authorized in accordance with the ADvantage approved service plan ~~of care~~.
(16) **Consumer-Directed Personal Assistance Services and Support(CD-PASS).**

(A) ~~Consumer-Directed Personal Assistance Services and Supports~~ CD-PASS are ~~Personal Services Assistance~~personal services assistance (PSA) and ~~Advanced Personal Services Assistance~~advanced personal services assistance (APSA) that enable ~~an individual~~a member 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 becomes the employer of record and employs the ~~Personal Services Assistant (PSA)~~ and~~/or~~ the ~~Advanced Personal Services Assistant (APSA)~~. ~~and~~The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring ~~that~~ the employment complies with ~~State~~ state and ~~Federal Labor Law~~federal labor law requirements. The member/employer 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~~the employer functions. The member/employer:

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

(ii) ~~provides~~is solely responsible to provide instruction and training to the PSA or APSA on tasks ~~to be done~~ and works with the ~~Consumer Directed Agent/Case Manager~~consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an ~~Advanced Personal Services Assistance~~APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ~~ASPA's~~APSA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within ~~Individual Budget Allocation~~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~~services the ~~Personal Services Assistance~~PSA may provide include:

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

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

(I) bathing and personal hygiene;

(II) dressing and grooming; and

(III) eating, including meal preparation and cleanup;

(iii) assistance with ~~homemaker type~~home services that may include shopping, laundry service, 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~~and 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~~An APSA provides assistance with ADLs to 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~~member were physically capable, and the procedure may be safely performed in the home. ~~Advanced Personal Services Assistance is a~~Services provided by the APSA are maintenance ~~service~~services and ~~should~~are never ~~be~~ used as ~~a~~ therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving ~~Advanced Personal Services Assistance~~APSA services ~~should be~~are referred to ~~their~~his or her attending physician, who ~~may, if~~when appropriate, order home health services. ~~The service of Advanced Personal Services Assistance~~APSA includes assistance with health maintenance activities that may include:
(i) routine personal care for persons with ostomies, ~~(~~including tracheotomies, gastrostomies, and colostomies with well-healed stoma~~),~~ ~~and~~ external, indwelling, and suprapubic catheters ~~which includes~~that include changing bags and soap and water hygiene around the ostomy or catheter site;
(ii) ~~remove~~removing external catheters, inspect skin, and reapplication of same;
(iii) ~~administer~~administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas (~~Pre~~pre-packaged only) ~~with members~~ without contraindicating rectal or intestinal conditions;
(iv) ~~apply~~applying medicated (prescription) lotions or ointments~~,~~ and dry, non-sterile dressings to unbroken skin;
(v) ~~use~~using a lift for transfers;
(vi) manually ~~assist~~assisting with oral medications;

(vii) ~~provide~~providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the service plan ~~of care,~~ unless contraindicated by underlying joint pathology;
(viii) ~~apply~~applying non-sterile dressings to superficial skin breaks or abrasions; and
(ix) ~~use Universal~~using universal precautions as defined by the ~~Center~~Centers for Disease Control and Prevention.
(D) ~~The service Financial~~Management ~~Services~~FMS are program administrative services provided to participating CD-PASS ~~employer/members~~members/employers by ~~the~~ ~~OKDHS/ASD~~DHS AS. ~~Financial Management Services~~FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:
(i) processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;
(ii) other employer related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's ~~Individual Budget Allocation~~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 on the member/employer's behalf;
(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~~ providing orientation and training regarding employer responsibilities, as well employer information and management guidelines, materials, tools and staff consultant expertise to support and assist the member in successfully performing employer-related functions; and
(v) ~~for~~ making ~~available~~ Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.
(E) The ~~service of Personal Services Assistance~~PSA service 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~~service plan.

(F) The ~~service of Advanced Personal Services Assistance~~APSA service 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~~service plan.

(17) ~~**Institution Transition Services**~~ **Institutional transition services.**

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

(B) ~~Institution Transition Case Management Services~~Transitional case management services are services ~~as described in~~per OAC 317:30-5-763(1) required by the ~~individual's plan of care~~member and included on the member's service plan~~, which~~that are necessary to ensure the health, welfare, and safety of the ~~individual~~member, or to enable the ~~individual~~member to function with greater independence in the home, and without which, the ~~individual~~member would continue to require institutionalization. ADvantage ~~Transition Case Management Services~~transitional case management services assist institutionalized ~~individuals~~members ~~that~~who are eligible to receive ADvantage services in gaining access to needed ~~waiver~~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. ~~TransitionCase Management Services~~Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay~~,~~ and for assisting the member transition from institution to home by updating the service plan, including necessary ~~Institution Transition Services~~institutional 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~~Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but ~~have been~~were referred by ~~the OKDHS/ASD~~ DHS AS to the ~~Case Management Provider~~case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

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

(ii) A unique modifier code is used to distinguish ~~Institution Transition Case Management~~transitional case management services from regular ~~Case Management~~case management services.
(C) Institutional ~~Transition Services~~transition services may be authorized and reimbursed ~~under the following~~per the conditions in (i) through (iv)~~:~~.
(i) The service is necessary to enable the ~~individual~~member to move from the institution to ~~their~~his or her home~~;~~.
(ii) The ~~individual~~member is eligible to receive ADvantage services outside of the institutional setting~~;~~.
(iii) Institutional ~~Transition Services~~transition services are provided to the ~~individual~~member within 180 calendar-days of discharge from the institution~~;~~.
(iv) ~~Transition Services~~services provided while the ~~individual~~member is in the institution are ~~to be~~ claimed as delivered on the day of discharge from the institution.
(D) ~~If~~When the member ~~has received~~receives ~~Institution Transition Services~~institutional transition services but fails to enter the ~~waiver~~Waiver, any ~~Institution Transition Services~~institutional transition services provided are not reimbursable.
(18) **Assisted ~~Living Services~~living services.**
(A) Assisted ~~Living Services~~living services (ALS) are personal care and supportive services ~~that are~~ furnished to ~~waiver~~Waiver members who reside in a homelike, non-institutional setting that includes 24-hour, on-site response capability to meet scheduled or unpredictable ~~resident~~member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, ~~(~~to the extent permitted under ~~State~~state law~~)~~. The ~~assisted living services~~ALS 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~~ALS. ADvantage reimbursement for ~~Assisted Living Services~~ALS includes services of personal care, housekeeping, laundry service, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise~~,~~ are to meet the member's specific needs ~~of the participant~~ as determined through the individualized assessment and documented on the ~~participant's~~member's service plan.

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

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

(i) ADvantage-certified ~~Assisted Living Centers~~assisted living centers (~~ALCs~~ ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one or more of the following:

(I) rental unit availability;

(II) the compatibility of the ~~participant~~ member 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; or

(IV) restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage ~~participants~~members. The number of rental units available to service the ADvantage participants may be altered based upon written request from the provider and acceptance by the ADvantage Administration (AA).

(iii) Mild or moderate, cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate ~~individuals~~members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage ~~Case Manager~~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, respect, and freedom from coercion and restraint. The ALC must optimize member’s initiative, autonomy and independence in making life choices. The ALC must

facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs ~~will~~ is not ~~be~~ recognized as a reason for determining ~~that~~ an ADvantage ~~participant's~~member'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~~:~~ listed in (I) through (III).

(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'~~the member's needs and choices; and provide members with 24-hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for ~~residents~~members with Alzheimer's disease and related dementias, physical disabilities, or other special needs ~~that~~ the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, will be utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

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

(viii) ~~Under~~Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person~~.~~, and includes

assistance with toileting." For ADvantage ~~Assisted Living Services~~ALS, assistance with "other personal needs" in this definition includes assistance with ~~toileting,~~ grooming and transferring. ~~and the~~The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ~~Assisted Living Services~~ALS 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~~that is incorporated as supplemental detail into the ADvantage comprehensive service plan. The ADvantage ~~Case Manager~~case manager in cooperation with ~~the Assisted Living Center~~ALC 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 in (I) through (IV) exist~~:~~.

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

(II) The member exhibits behavior or actions that repeatedly and substantially ~~interferes~~interfere 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~~the ALC attempted interventions to resolve behavior problems~~;~~.

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

(IV) The member fails to pay room and board charges and/or ~~the OKDHS~~DHS 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~~ALC must inform the member and~~/or~~ the member's representative, if any, the AA and the member's ADvantage ~~Case Manager~~case manager. The ALC must develop a discharge plan in consultation with the member, the member's ~~support network~~representative, the ADvantage ~~Case Manager~~case manager, and the AA. The ALC and ~~Case Manager~~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~~transitioning out of the ALC, ~~if~~when the 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~~case manager and the AA, giving the member 30 calendar-days, written notice of the ALC's intent to terminate the residency agreement and move the member to ~~a more~~an appropriate care provider. The 30 calendar-day requirement ~~shall~~must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents ~~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 notice date ~~of the notice~~;

(III) the date notice was given to the member and the member's representative, the ADvantage Case Manager, and the AA;

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

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

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

(i) Physical environment.

(I) The ALC must provide lockable doors on the entry door of each rental unit and ~~a~~an attached, lockable compartment within each member unit for valuables. ~~Member residents~~Members must have exclusive rights to ~~their units~~his or her unit with lockable doors at the entrance of ~~their~~the individual ~~and/~~or shared rental unit ~~and to a lockable compartment within each member's rental unit for valuables, except in the case of documented contraindication.~~Keys to rooms may be held by appropriate ALC staff as designated by the member's choice. Rental units may be shared only ~~if~~when a request to do so is initiated by the member ~~resident~~. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement (lease) with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord tenant law of the state, county, city, or other designated entity.

~~(II)~~(III) The ALC must provide each rental unit with a means for each member ~~resident~~ to control the temperature in the ~~individual living~~residential unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the ~~resident~~member 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)~~(IV) For ~~ALCS~~ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, ~~(~~including closets and storage ~~area)~~areas, 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)~~areas, of 360 square feet.

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

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

~~(VI)~~(VII) The member is responsible for furnishing ~~their~~ the 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~~ADvantage case manager in coordination with the ALC must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

~~(VII)~~(VIII) 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)~~(IX) The ALC must ensure the design of common areas accommodates the special needs of ~~their~~the resident population and that the rental unit accommodates the special needs of the ~~individual~~member in compliance with ~~ADA Accessibility Guidelines~~the Americans with Disabilities Act accessibility guidelines per ~~(~~28 ~~CFR~~Code of Federal Regulations, Part 36, Appendix A~~),~~ at no additional cost to the member.

~~(IX)~~(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be

proportionate to the number of residents and appropriate for the resident population.
~~(X)~~(XI) The ALC must provide appropriately monitored outdoor space for resident use.
(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed, but may be limited by the ALC to the extent to which a visitor may stay overnight.
~~(XII)~~(XIII) The ALC must be physically accessible to members.
(ii) Sanitation.
(I) The ALC must maintain the facility, including its individual rental units~~,~~ that ~~is~~are 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 rental units ~~that maintains~~to maintain a safe, clean, and sanitary environment.
(V) The ALC must have policies and procedures for members' pets.
(iii) Health and Safety.
(I) The ALC must provide building security that protects ~~residents~~members from intruders with security measures appropriate to building design, ~~environment~~environmental risk factors, and the resident population.
(II) The ALC must respond immediately and appropriately to missing ~~residents~~members, 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 (OSDH).
(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.
(V) The ALC must provide services and facilities that accommodate the needs of ~~resident~~members to safely evacuate in the event of fires or other emergencies.
(VI) The ALC must ensure ~~that~~ staff is 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~~members.
(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~~/~~or recreational outings.
(iv) Staff to resident ratios.
(I) The ALC must ensure ~~that~~ a sufficient number of trained staff are on duty, awake, and present at all times, 24 hours a day, and seven days a week, to meet the needs of residents and to carry out all of 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~~members in accordance with each ~~individual's~~member's ADvantage ~~Service Plan~~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~~has qualifications consistent with their job responsibilities.
(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by ~~the Oklahoma Department of Health~~OSDH.
(III) The ALC must provide staff orientation and ongoing training to develop and maintain ~~the~~staff 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 ~~or memory care~~ unit must receive four additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count ~~towards~~toward 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~~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~~member health and nutritional status.
(vii) Resident rights.
(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in ~~O.S. 63-1-1918~~Section 1-1918 of Title 63 of the Oklahoma Statutes (O.S. 63-§-1-1918) amended to include additional rights and the clarification of rights as listed in the ADvantage ~~assisted living~~ Member 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~~member, the ~~resident's~~member's representative, or ~~where appropriate,~~ the ~~court appointed~~legal 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~~/~~ and appeal rights, including a description of the process for submitting a grievance~~/~~or appeal of any decision that decreases Medicaid services to the member.
(viii) Incident reporting.
(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage ~~Case Manager~~case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also to be made to Adult Protective Services (APS) and to the Oklahoma State Department of Health (OSDH), as appropriate, in accordance with the ALC's licensure rules, utilizing the specific reporting forms required.
(II) Incidents requiring report by licensed ~~Assisted Living Centers~~ALC are those defined by ~~the Oklahoma State Department of Health (~~OSDH~~) in~~per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting Form.
(III) Reports of incidents must be made to the member's ADvantage ~~Case Manager~~case manager and to the AA via facsimile or mail within one business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. If required, a follow-up report of the incident must ~~will~~ be submitted via facsimile or mail to the member's ADvantage ~~Case Manager~~case manager and to the AA.~~,~~ The follow up report must be

submitted within five business days ~~after~~ of the incident. The final report must be filed with the member's ADvantage ~~Case Manager~~case manager and ~~to~~ the ~~ADvantage Administration~~AA when the ~~full~~ investigation is complete, not to exceed ~~ten~~10 business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to 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~~,DHS Adult Protective Services (APS) ~~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~~perO.S. 43A § 10-104.A. Reports ~~should~~are also ~~be~~ made to ~~the~~ OSDH, as appropriate, ~~in accordance with the ALC's~~per ALC licensure rules.

(V) The preliminary incident report must at the minimum, include who, what, when, ~~and~~ where, and the measures taken to protect the member and 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 investigation findings ~~of the investigation~~. The final report at ~~the~~a 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~~When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services.

(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~~case manager for delivery of necessary health services. The ADvantage ~~Case Manager~~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. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ~~Assisted Living Services~~ALS are billed per diem of service for days covered by the ADvantage member's service plan and during which the ~~Assisted Living Services~~ALS provider is responsible for providing ~~Assisted Living service~~das needed ~~by~~ALSfor the member. The per diem rate for ~~the~~ ADvantage

assisted living services for a member ~~will be~~is one of three per diem rate levels based ~~upon individual~~on a member's need for ~~service-~~type of, intensity of, and frequency of service to address member ~~ADL/IADL~~ADLs, IADLs, and health care needs. The rate level is based ~~upon~~ on the Universal Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage ~~Case Manager~~case manager employed by a ~~Case Management~~case management agency ~~that is~~ independent of the ~~Assisted Living Services~~ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

New Business

I. Meeting Schedule for 2016

The Medical Advisory Committee Meetings are held on the 3rd Thursday of odd-numbered months and they are as follows:

January 21, 2016
March 17, 2016
May 19, 2016
July 21, 2016
September 15, 2016
November 17, 2016

Spring break typically falls during our March Medical Advisory Committee Meeting time so we will need to know if we will have a quorum to proceed with our March meeting.

II. Election of Chairperson and Vice-Chairperson