OHCA MEDICAL ADVISORY COMMITTEE

AGENDA

May 19, 2016
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 April 25, 2016 Medical Advisory Committee Meeting

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

VI. SoonerCare Operations Update: **Casey Dunham, Director Provider/Medical Home Services**
   A. Introduction of Casey Dunham to the MAC – **Dr. Steve Crawford**
   B. Presentation of SoonerCare Operations – **Casey Dunham**

VII. Legislative Verbal Update: **Emily Shipley, Director of Governmental Affairs**

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

IX. Action Item: Vote on Proposed Rule Changes: **Chairman, Steven Crawford, M.D.**
   A. Item #16-07 - Advantage Waiver

X. Information Items Only – not actionable:
   A. Access Monitoring Review Plan - Melinda Thomason
   B. 2017-2018 SoonerCare Choice and Insure Oklahoma 1115(a) Demonstration Waiver Extension Request – Sherris Harris-Ososanya

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

XII. Future Meetings

July 21, 2016 at 1:00 PM

September 15, 2016 at 1:00 PM

November 17, 2016 at 1:00 PM

XIII. Adjourn

MAC Minutes for April 25, 2016

Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:00 PM. He cautioned the committee as well as the audience about the sensitivity of the mics and to keep sidebars down. He then asked for the roll call to be taken. ***Delegates present were***: Dr. Joe Catalano, Dr. Steve Crawford, Ms. Wanda Felty, Dr. Stanley Grogg, Mr. Mark Jones, Ms. Annette Mays, Ms. Toni Pratt-Reid, Dr. Edd Rhoades, Mr. David Rising, Ms. Carrie Slatton-Hodges, Mr. Rick Snyder, and Mr. Jeff Tallent.
Alternates present were: Ms. Sarah Baker, Ms. Frannie Pryor, Mr. Victor Clay, Dr. Gail Poyner, and Dr. Mike Talley providing a quorum.

Delegates absent without an alternate were: Ms. Mary Brinkley, Dr. David Cavallaro, Ms. Samantha Galloway, Dr. Melissa Gastorf, Mr. Steve Goforth, Dr. Ashley Orynich, Mr. James Patterson, Dr. Daniel Post, Dr. Jason Rhynes, and Dr. Kanwal Obhrai.

Introduction of Melody Anthony

Dr. Crawford introduced Melody Anthony to the MAC. Melody has been with the Agency since 2006 when she began as the Provider Service Director. She was a leading member of the team which transitioned the SoonerCare Choice program in 2009 from a partially capitated case management program to the current Patient Centered Medical Home delivery system. In March, 2016 she was named the Deputy State Medicaid Director and will be a representative of the Agency to the MAC.

Public Comments

Dr. Crawford asked for public comments and then instructed the audience on the policy of making a public comment. The comments are as follows:

1. Jeanette Moore, Executive Director with Hope Community Services, a private non-profit agency who provides therapy, sees children and elderly, has adequate access to services, and no long waiting lists to get into their program. They saw 7400 patients last year. She reminded everyone that cuts have to happen and asks that the recommendations be considered and accepted because they come from experts with national standing.

2. Diana Sturdevant, with Mitchell Manor Convalescent Home in McAlester, who requested to show what the financial crisis and any type of provider cut would look like to the industry. At our current spending rate there would be 29% of nursing homes that would be insolvent this year which means 85 facilities are at high risk of closure and displacing approximately 5500 residents. This would also eliminate 5500 jobs which results in a devastating economic impact to these communities. Oklahoma currently has one of the lowest Medicaid reimbursement rates to nursing homes in the country at a rate of 55% of the Medicare fee schedule. She asks that the MAC consider the catastrophic affects that these cuts would create.

3. Adam Stephens, a Long Term Care Administrator, states that over the past 10 years the cost to nursing home residents have increased drastically but reimbursement rates to provide such care has

gone down. The widening gap between cost and reimbursement has caused many nursing homes to close. To put that in perspective, ten years ago there were 400 nursing homes and now we have just under 300, which is a 25% closure rate within a decade. The proposed 25% rate cut would cause the 95% remaining to close and even a 5% cut will be catastrophic particularly to rural facilities or facilities whose population is primarily Medicaid.

4. Lori Holmquist-Day, a practicing clinical Psychologist and the Chairman for Mental Health Service Providers Division of OPA, who has been working cooperatively to open up new doors for LPCs and LMFTs in terms of job opportunities. At this particular time in Oklahoma, LPCs and LMFTs have more job options outside of independent practices and agencies that they are currently working on. There are new rule changes going into effect that will open up new jobs for Masters level providers under the supervision of a Psychologist or Physician. There are also job opportunities for Masters level providers in group practices under MDs or PhDs. This rate and policy change does not necessarily mean that Master level providers will go without jobs or stop providing services to Oklahomans. This change will only affect the fabric or landscape by improving the quality and access to mental health services under the model that provides better oversight and supervision with goals of reducing waste and at the same time improving quality of care by insuring evidence based models and practices are being used to treat our families in Oklahoma. The structure looks the same, very similar to MDs and DOs working with MNPs and PAs which have always been given the dramatic differences in education, clinical training, and evidence based models intervention.

5. Debra Knight, a parent who asks if Oklahoma is caring for its children is discretionary because it seems that OHCA is treating it like an optional budget item. In order for these budget cuts to take effect, OHCA is depending on the fact that all of the patients that Licensed Behavioral Health Providers see do not get in the agency. There is not a waiting list now but there will be. If they all get in, there is no budget cut but an actual increase. It is prioritizing healthcare based on assessment. We can't put our children on a shelf in suspended animation until we can figure this out.

6. Summer King, the Clinical Director of HOPE Community Services, a community mental health center and a private agency acknowledges that at these times of crisis, she looks to leadership that she has trusted in and has known from a national standpoint that can view the whole picture. They look at all kinds of data whether it is the claims that are reimbursed, the outcome measurements that are achieved through all of our services and I have to put my trust and faith in them that they are making a reasonable and sound decision with the limits that are given to them. I urge you to accept the limits that they are proposing with the policy and rate changes. It is a hard time and we need to band together and make our voice heard at the Capitol to affect those that are giving us the limited budget that we are able to deal with.

7. Tara Warwick, owner of a small private therapy company and employs Behavioral Health Therapists, who comes to the meeting with confused and sad feelings. As a business owner, she goes over the numbers daily and sees that OHCA has decreased rates, decreased units now, has increased caseloads, and are going to get rid of private therapists and this is reinforcing agencies overhead. In looking at all of the changes she feels that it is going to kill some private agencies and reinforce

some of the larger agencies. She is seeing some of her colleagues doing the same thing that she is doing and that is to get in with an agency. This will produce a lot more agencies providing services at a higher cost and more units and once again will increase debt. If this passes it is taking away family values, private business owner values, and the values of keeping some control in the hands of the people.

8. Richard DeSirey, Managing Partner of A New Way Center, pointed out that this is not about cutting money but it is about destroying a class of providers which has been an agenda of the Department of Mental Health (DMH) since it was first started. There was a 30% rate cut this morning and now there is a 50% reduction in services. This will destroy them. He is supportive of systems of care but the expert is the family not the leadership of the DMH. He is a private small business owner which seemed to be valued up until now. The DMH has a conflict of interest with their community of Mental Health system. They are not affected by this at all because there is no rate cut. It is with limited services which is consistent with the services they provide. When these clients go into these Mental Health Centers they will get enhanced rates, which takes them almost to a 100% Medicare rate and they will have their Health Homes benefit by hundreds or thousands per member per month automatically. Therapists will go into the community Mental Health Centers from private practice which will finally give them better capacity. This is not about a rate cut but about destroying a class of providers.

9. Cherry Dienz, Independent Provider, pointed out that it does not only affect her as a mental health provider but also as a parent of a child with disabilities. The only thing that comes to her mind when she talks about Oklahoma now is that we have become a backward, backwater hierarchy with all of the money flowing to the top tier and now we are getting down to the nitty gritty. She does not believe that Oklahoma cares for its own or has family values anymore. All of that has been destroyed and we have moved back to the 1950s.

10. Todd Palmer, a small agency owner as well as a member of the Oklahoma Counseling Association, who observed flags on the Capitol lawn which was recognizing Child Abuse Victims and thought what a terrible irony it is that the decision that is going to be discussed today will absolutely guarantee more flags on the lawn next year. The proposed cuts continue to keep this state at the top of the Nation's list for the most incarcerated with mental illness. The last meeting here showed how proposed cuts from our legislative bodies have divided us as professionals. He noted that it is sad to see peer against peer and he came to encourage the providers to stand together against this and other proposals like it. As long as OHCA and DMH or any other committee or governing body wants to move money around on their ledger and make cuts to any mental health service, it is our duty to stand against this and to stand together and not let them divide us. The citizens of Oklahoma need our voice to protect them and we need to take our own advice that we give in therapy and stand up for ourselves and for the business of mental health in Oklahoma. If we don't, the writing is on the wall of how bleak our future really is.

11. Robert Lobato, owner of Youth Care of Oklahoma, an Agency that was started over 20 years ago. In addition to behavioral health we provide therapeutic foster care, foster care, and health home. These rule changes before us are a shared pain. Not only are the hours going down for the

Independent Contractors, they are also going down for agencies. This shared pain is something that needs to happen when we have the budget cuts that are needed to keep the Agency or DMH operating. There are always options available to these Independent Contractors who feel that they are the only ones suffering any pain. I, as a business owner, have over 200 employees at 25 offices. They talked about being out in rural areas but I have offices in rural areas that I have never seen an Independent Contractor. These individuals have the option of accepting what is being presented to them, start their own agency, or go ahead and join an agency. I am in favor of these options.

12. Chuck Edgington, the founder and owner of a small private practice in the Oklahoma City area who primarily treat children with developmental disabilities. Children with autism are one of their primary constituencies. Most private agencies do not accept insurance from private insurers which leaves children essentially without access to specialized services. We called 15 mental health agencies in the local community and asked specifically if they provided services to children with autism. We did this because we were recently told that the DMH made it impossible to seek a prior authorization for mental health therapy to use autism as their primary diagnosis code and we were told it is because that is not a psychiatric diagnosis. We were also told that our agency is an outlier, statistically speaking, for children who are seeking authorization for that diagnosis. That is because we specialize in the treatment of children with autism. The agencies that we contacted including the largest agencies in the state, told us that if they do have services for autism they have "a" therapist who may be able to help them unless the child is non-verbal in which case they refer to our agency. There are three agencies that we contacted and were told that they do not have therapy services for children with autism but we refer them to agency "X" and agency "X" refers them to us.

No other public comments were made.

Member Comments and Approval of Minutes

Dr. Crawford asked if any member of the MAC had a comment or discussion. There were no comments or discussion by the Medical Advisory Committee. Dr. Crawford then asked for a motion to accept and approve the Minutes of the March 10, 2016 meeting. Dr. Stanley Grogg moved for acceptance; Mr. Jeff Tallent seconded the motion and it passed unanimously.

Summary of ODMHSAS Emergency Rule Changes:

Traylor Rains-Sims, Director, Policy and Planning, ODMHSAS informed the MAC of the most recent Rules Changes due to the revenue shortfall as follows:

A) Item #16-04: After the reading of the summary and a brief discussion of how Oklahoma compares to other national agencies, Dr. Stanley Grogg moved for acceptance; Dr. Joe Catalano seconded the motion and it passed unanimously.

B) Item #16-05: After the reading of the summary, the question was asked that if the Rebalancing Act, if passed, would help with this issue and Mr. Traylor Rains-Sims responded that the passing of the Rebalancing Act would help all of the issues. Ms. Sarah Baker asked if things would go back to the way they were if passed and Traylor stated that it would. Ms. Baker then asked if there will be PA

policy in place that would allow for additional units to those who require it and Mr. Traylor Rains-Sims responded that under the federal requirement of EPSDT, they are always required to evaluate the medical necessity and if it is determined that the individual actually needed more and is medically necessary, DMH would have a mechanism in place. Mr. Jeff Tallent moved for acceptance; Dr. Mike Talley seconded the motion and it passed unanimously.

C) **Item #16-06:** After the reading of the summary, Mr. Jeff Tallent moved for acceptance; Dr. Stanley Grogg seconded the motion and it passed unanimously.

New Business / Member Comments

No new business was discussed. Dr. Crawford reminded the audience that the MAC is advisory only to the Board and the Board is required to have a balanced budget as is the State. He encouraged them to get in touch with their Legislators today and voice their concerns over the need to increase funding for healthcare as well as mental health. Ms. Carrie Slayton-Hodges informed everyone about a proposal that the Governor's office put forth that proposes to restore these funds so that is her intention right now but the actions that are required to do that are not getting much attraction. She is looking for a way legislatively to put this money back in to our budget for 2016. If that were the case, these would only need to be in effect until we could come back around again and approve the changes. Ms. Slayton-Hodges went on to say that the mechanism the Governor proposed was to do bonds for transportation which would free up a specific amount that would be added back in to the budget. Dr. Catalano stated that the Oklahoma Nurses Association has been working very hard to get the Rebalancing Act passed. He urged everyone to speak passionately about this to the Legislators but the simple fact is it is about the money right now. If Mr. Gomez' plan passes there will be matching money from the government under a Waiver and it would actually cover all of the expenses mentioned. Dr. Gail Poyner voiced her concern that the cigarette tax will not totally go to OHCA that there will be others fighting for that money as well. Ms. Sarah Baker announced that there is going to be a Medicaid Matters Rally on Tuesday, May 3rd from 11:00 AM - 1:00 PM on the south plaza of the State Capitol for the purpose of asking our state legislators to apply this money only to healthcare and Insure Oklahoma. She encouraged everyone to attend that rally. Dr. Crawford asked if anyone from OHCA that would like to speak to the issue and Dr. Garth Splinter, Deputy CEO of OHCA, responded by saying that there is always a danger as funding bills go forward that other people will say "we are just as needy and worthy and we should have our share of that". The good thing about this though is that most of the support that has been showing up in the legislature is in a way that is fairly committed to keeping these funds in the Medicaid sphere and the Department of Mental Health and some maybe at DHS so in terms of supporting the medical delivery system for all citizens of Oklahoma. That is how we have been talking about it. There has been this drift over the last ten years or so, back to thinking of Medicaid as a welfare program, I think this whole problem with the budget is making people realize again that it is really much more than the financial bedrock to lots of the delivery system. The rural healthcare delivery system in particular just can't get by without this money coming in. I tend to think that there is always a danger to people trying to latch on. Luckily, we have education though moving strongly toward a vote of the people with a sales tax and that would have been the biggest area of fight over funding. It is slowly sinking in about what the consequences will be and we, as an agency, can't be advocates and can't lobby but we can talk about what the facts are or what the needs are and what the consequences are so we have been doing that and other people have been picking up the ball and taking it down the court. It is actually quite amazing that it is moving along the way that it is. Three-fourths majority in both houses is a very difficult thing to

obtain. I am only aware of that happening twice since we passed amendment 640 approximately 20 years ago. Dr. Splinter offered to answer any questions but no questions were asked.

Melinda Thomason, assistant director of federal and state authorities, presented information about the new agency Access Monitoring Review Plan that is in development. All Medicaid programs are required to prepare a plan under federal regulations that became effective January 4, 2016. In addition, any state plan amendment that is a rate reduction or provider payment restructuring that is submitted by a Medicaid agency after July 1, 2016, will necessitate a focused update to the plan with ongoing monitoring for a minimum of three years.

OHCA has formed a project team that includes participation from throughout the agency and from external partners including the Health Department, Department of Human Services and the Department of Mental Health and Substance Services. Miguel Soto from the Division of Strategic Planning and Reform (DSPAR) is the Project Manager.

In accordance with the regulations, the plan is to be developed in consultation with the Medical Advisory Committee. Ms. Thomason described the initiation of the draft that has been undertaken by the workgroup thus far. Originally CMS set a July 1 deadline for submission of the plans, although the deadline has been extended to October 1.

The draft Access Monitoring Review Plan will be posted for public comment April 18, 2016, through May 19, 2016. At the May 19, 2016, Ms. Thomason will bring the draft to the meeting of the Medical Advisory Committee for input from committee members to complete the consultation on the plan.

Future Meetings

Dr. Crawford reminded the MAC that May 19, 2016 is the next meeting date followed by July 21, 2016, September 15, 2016, and November 17, 2016.

Adjournment

Dr. Crawford asked for a motion to adjourn. It was provided by Dr. Stanley Grogg; Mr. Jeff Tallent seconded and the meeting was adjourned.

Agenda

FINANCIAL REPORT

For the Seven Months Ended January 31, 2016
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$2,375,487,743** or at budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,315,841,488 or .5% under** budget.
- The state dollar budget variance through January is a **positive $10,784,259.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	2.7
Administration	2.7
Revenues:	
Drug Rebate	3.0
Taxes and Fees	2.5
Overpayments/Settlements	(.1)
Total FY 16 Variance	**$ 10 .8**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 205: Supplemental Hospital Offset Payment Program Fund 4
Fund 230: Quality of Care Fund Summary 5
Fund 245: Health Employee and Economy Act Revolving Fund 6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund 7

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2016, For the Seven Month Period Ending January 31, 2016

REVENUES	FY16 Budget YTD	FY16 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 547,324,629	$ 547,324,629	$ -	0.0%
Federal Funds	1,362,872,491	1,352,355,915	(10,516,576)	(0.8)%
Tobacco Tax Collections	26,985,095	29,534,859	2,549,764	9.4%
Quality of Care Collections	44,844,814	44,374,297	(470,517)	(1.0)%
Prior Year Carryover	67,016,727	67,016,727	-	0.0%
Federal Deferral - Interest	179,979	179,979	-	0.0%
Drug Rebates	138,821,582	146,529,495	7,707,913	5.6%
Medical Refunds	24,850,350	24,600,770	(249,580)	(1.0)%
Supplemental Hospital Offset Payment Program	151,139,051	151,139,051	-	0.0%
Other Revenues	12,031,799	12,432,022	400,223	3.3%
TOTAL REVENUES	**$ 2,376,066,516**	**$ 2,375,487,743**	**$ (578,774)**	**(0.0)%**

EXPENDITURES	FY16 Budget YTD	FY16 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 32,121,735**	**$ 29,144,529**	**$ 2,977,206**	**9.3%**
ADMINISTRATION - CONTRACTS	**$ 54,736,325**	**$ 51,472,388**	**$ 3,263,937**	**6.0%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	23,619,630	23,169,161	450,469	1.9%
Acute Fee for Service Payments:				
Hospital Services	516,060,805	515,082,541	978,264	0.2%
Behavioral Health	11,420,979	11,471,231	(50,252)	(0.4)%
Physicians	266,105,994	265,762,703	343,291	0.1%
Dentists	75,854,850	75,362,811	492,040	0.6%
Other Practitioners	25,366,021	25,363,616	2,405	0.0%
Home Health Care	11,498,490	11,479,804	18,686	0.2%
Lab & Radiology	35,532,100	35,251,546	280,554	0.8%
Medical Supplies	26,593,903	26,161,146	432,757	1.6%
Ambulatory/Clinics	74,590,007	74,021,157	568,850	0.8%
Prescription Drugs	300,616,113	300,099,305	516,807	0.2%
OHCA Therapeutic Foster Care	497,937	261,418	236,519	47.5%
Other Payments:				
Nursing Facilities	330,674,360	330,166,938	507,422	0.2%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	35,052,027	35,190,656	(138,629)	(0.4)%
Medicare Buy-In	80,649,243	80,762,709	(113,466)	(0.1)%
Transportation	37,944,658	37,533,418	411,240	1.1%
Money Follows the Person-OHCA	410,392	240,819	169,573	0.0%
Electonic Health Records-Incentive Payments	3,981,987	3,981,987	-	0.0%
Part D Phase-In Contribution	47,042,109	47,035,908	6,201	0.0%
Supplemental Hospital Offset Payment Program	333,326,339	333,326,339	-	0.0%
Telligen	3,499,359	3,499,359	-	0.0%
Total OHCA Medical Programs	**2,240,337,302**	**2,235,224,571**	**5,112,731**	**0.2%**
OHCA Non-Title XIX Medical Payments	9,158	-	9,158	0.0%
TOTAL OHCA	**$ 2,327,204,520**	**$ 2,315,841,488**	**$ 11,363,032**	**0.5%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 48,861,996**	**$ 59,646,255**	**$ 10,784,259**	

Agenda

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures

by Source of State Funds

SFY 2016, For the Seven Month Period Ending January 31, 2016

Category of Service	Total	Health Care Authority		Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 23,248,044	$ 23,161,747	$ 23,169,161	$ -	$ 78,883	$ -	$ 7,414	$ -
Inpatient Acute Care	754,572,578	351,374,374	594,102,869	283,901	2,155,769	241,196,494	1,248,100	158,313,939
Outpatient Acute Care	235,969,437	160,191,339	233,835,052	24,269	2,134,385	71,658,886	1,960,558	
Behavioral Health - Inpatient	31,653,987	6,824,199	26,256,864	-	145,877	19,432,665	-	5,251,246
Behavioral Health - Psychiatrist	5,685,325	4,647,031	5,685,325	-	-	1,038,294	-	-
Behavioral Health - Outpatient	16,170,373	-	-	-	-	-	-	16,170,373
Behaviorial Health-Health Home	12,470,424	-		-	-	-	-	12,470,424
Behavioral Health Facility- Rehab	144,084,343	-	-	-	-	-	44,560	144,084,343
Behavioral Health - Case Management	10,470,635	-	-	-	-	-	-	10,470,635
Behavioral Health - PRTF	46,793,696	-	-	-	-	-	-	46,793,696
Residential Behavioral Management	11,806,182	-	-	-	-	-	-	11,806,182
Targeted Case Management	39,268,572	-	-	-	-	-	-	39,268,572
Therapeutic Foster Care	261,418	261,418	261,418	-	-	-	-	-
Physicians	299,914,127	262,564,194	265,762,703	33,892	863,843	-	3,164,617	33,287,581
Dentists	75,371,903	75,352,798	75,362,811	-	9,092	-	10,012	-
Mid Level Practitioners	1,452,865	1,444,554	1,444,888	-	7,976	-	334	-
Other Practitioners	23,964,331	23,654,652	23,918,727	260,379	45,604	-	3,696	-
Home Health Care	11,485,603	11,474,672	11,479,804	-	5,799	-	5,132	-
Lab & Radiology	36,003,092	35,027,258	35,251,546	-	751,546	-	224,288	-
Medical Supplies	26,309,684	24,558,199	26,161,146	1,581,727	148,539	-	21,220	-
Clinic Services	74,279,386	69,906,799	69,998,781	-	347,095	-	91,982	3,933,510
Ambulatory Surgery Centers	4,094,222	4,014,055	4,022,377	-	71,845	-	8,322	-
Personal Care Services	7,365,636	-		-	-	-	-	7,365,636
Nursing Facilities	330,166,938	207,704,655	330,166,938	122,456,420	-	-	5,863	-
Transportation	37,433,599	35,867,257	37,433,599	1,541,190	-	-	25,152	-
GME/IME/DME	61,536,864	-		-	-	-	-	61,536,864
ICF/IID Private	35,190,656	28,751,162	35,190,656	6,439,494	-	-	-	-
ICF/IID Public	19,046,296	-	-	-	-	-	-	19,046,296
CMS Payments	127,798,617	127,376,203	127,798,617	422,414	-	-	-	
Prescription Drugs	306,630,882	299,129,017	300,099,305	-	6,531,577	-	970,288	-
Miscellaneous Medical Payments	99,819	99,311	99,819	-	-	-	508	-
Home and Community Based Waiver	115,046,836	-	-	-	-	-	-	115,046,836
Homeward Bound Waiver	50,322,759	-	-	-	-	-	-	50,322,759
Money Follows the Person	3,320,567	240,819	240,819	-	-	-	-	3,079,748
In-Home Support Waiver	14,881,942	-	-	-	-	-	-	14,881,942
ADvantage Waiver	104,398,963	-	-	-	-	-	-	104,398,963
Family Planning/Family Planning Waiver	3,192,198	-	-	-	-	-	-	3,192,198
Premium Assistance*	26,352,676	-	-	-	26,352,676	-	-	-
Telligen	3,499,359	3,499,359	3,499,359	-	-	-	-	-
Electronic Health Records Incentive Payments	3,981,987	3,981,987	3,981,987	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,135,596,820**	**$ 1,761,107,060**	**$ 2,235,224,571**	**$ 133,043,686**	**$ 39,650,506**	**$ 333,326,339**	**$ 7,792,046**	**$ 860,721,743**

* Includes $26,169,149 paid out of Fund 245

Agenda

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2016, For the Seven Month Period Ending January 31, 2016

REVENUE		FY16 Actual YTD
Revenues from Other State Agencies	$	360,372,740
Federal Funds		530,095,740
TOTAL REVENUES	**$**	**890,468,480**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	115,046,836
Money Follows the Person		3,079,748
Homeward Bound Waiver		50,322,759
In-Home Support Waivers		14,881,942
ADvantage Waiver		104,398,963
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		19,046,296
Personal Care		7,365,636
Residential Behavioral Management		8,860,988
Targeted Case Management		33,022,598
Total Department of Human Services		**356,025,766**
State Employees Physician Payment		
Physician Payments		33,287,581
Total State Employees Physician Payment		**33,287,581**
Education Payments		
Graduate Medical Education		22,912,701
Graduate Medical Education - Physicians Manpower Training Commission		2,436,996
Indirect Medical Education		32,248,316
Direct Medical Education		3,938,851
Total Education Payments		**61,536,864**
Office of Juvenile Affairs		
Targeted Case Management		1,825,686
Residential Behavioral Management		2,945,193
Total Office of Juvenile Affairs		**4,770,879**
Department of Mental Health		
Case Management		10,470,635
Inpatient Psychiatric Free-standing		5,251,246
Outpatient		16,170,373
Health Homes		12,470,424
Psychiatric Residential Treatment Facility		46,793,696
Rehabilitation Centers		144,084,343
Total Department of Mental Health		**235,240,717**
State Department of Health		
Children's First		921,255
Sooner Start		1,395,652
Early Intervention		2,894,151
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,174,842
Family Planning		87,603
Family Planning Waiver		3,090,739
Maternity Clinic		6,803
Total Department of Health		**9,571,045**
County Health Departments		
EPSDT Clinic		436,740
Family Planning Waiver		13,856
Total County Health Departments		**450,596**
State Department of Education		**114,265**
Public Schools		**490,617**
Medicare DRG Limit		**151,783,776**
Native American Tribal Agreements		**919,472**
Department of Corrections		**735,918**
JD McCarty		**5,776,245**
Total OSA Medicaid Programs	**$**	**860,703,743**
OSA Non-Medicaid Programs	**$**	**41,458,875**
Accounts Receivable from OSA	**$**	**11,694,139**

Agenda

SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2016, For the Seven Month Period Ending January 31, 2016

REVENUES				FY 16 Revenue
SHOPP Assessment Fee				$ 150,858,793
Federal Draws				204,767,500
Interest				71,234
Penalties				209,024
State Appropriations				(22,600,000)
TOTAL REVENUES				$ 333,306,551

EXPENDITURES	Quarter	Quarter	Quarter	FY 16 Expenditures
Program Costs:	7/1/15 - 9/30/15	10/1/15 - 12/31/15	1/1/16 - 3/31/16	
Hospital - Inpatient Care	83,225,354	84,459,469	73,511,671	$ 241,196,494
Hospital -Outpatient Care	22,465,442	22,826,470	26,366,973	71,658,886
Psychiatric Facilities-Inpatient	6,265,547	6,748,918	6,418,199	19,432,665
Rehabilitation Facilities-Inpatient	392,213	397,771	248,311	1,038,294
Total OHCA Program Costs	112,348,555	114,432,629	106,545,155	$ 333,326,339
Total Expenditures				$ 333,326,339
CASH BALANCE				$ (19,788)

*** Expenditures and Federal Revenue processed through Fund 340

Agenda

SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2016, For the Seven Month Period Ending January 31, 2016

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 44,349,113	$ 44,349,113
Interest Earned	25,185	25,185
TOTAL REVENUES	**$ 44,374,297**	**$ 44,374,297**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 120,345,114	$ 46,272,696	
Eyeglasses and Dentures	159,346	61,268	
Personal Allowance Increase	1,951,960	750,529	
Coverage for Durable Medical Equipment and Supplies	1,581,727	608,174	
Coverage of Qualified Medicare Beneficiary	602,441	231,638	
Part D Phase-In	422,414	162,418	
ICF/IID Rate Adjustment	3,046,209	1,171,267	
Acute Services ICF/IID	3,393,285	1,304,718	
Non-emergency Transportation - Soonerride	1,541,190	592,588	
Total Program Costs	**$ 133,043,686**	**$ 51,155,297**	**$ 51,155,297**
Administration			
OHCA Administration Costs	$ 305,217	$ 152,609	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 305,217**	**$ 152,609**	**$ 152,609**
Total Quality of Care Fee Costs	**$ 133,348,903**	**$ 51,307,906**	
TOTAL STATE SHARE OF COSTS			**$ 51,307,906**

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.

Agenda

SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2016, For the Seven Month Period Ending January 31, 2016

REVENUES	FY 15 Carryover	FY 16 Revenue	Total Revenue
Prior Year Balance	$ 27,746,235	$ -	$ 1,498,834
State Appropriations	(25,000,000)	-	-
Tobacco Tax Collections	-	24,292,307	24,292,307
Interest Income	-	123,932	123,932
Federal Draws	235,637	17,189,684	17,189,684
TOTAL REVENUES	**$ 2,981,872**	**$ 41,605,923**	**$ 43,104,757**

EXPENDITURES	FY 15 Expenditures	FY 16 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 26,169,149	$ 26,169,149
College Students		183,528	70,566
Individual Plan			
SoonerCare Choice		$ 75,324	$ 28,962
Inpatient Hospital		2,141,887	823,556
Outpatient Hospital		2,100,567	807,668
BH - Inpatient Services-DRG		142,186	54,670
BH -Psychiatrist		-	-
Physicians		836,846	321,767
Dentists		5,431	2,088
Mid Level Practitioner		7,877	3,029
Other Practitioners		45,067	17,328
Home Health		5,799	2,230
Lab and Radiology		736,942	283,354
Medical Supplies		142,597	54,829
Clinic Services		342,640	131,745
Ambulatory Surgery Center		71,597	27,529
Prescription Drugs		6,442,010	2,476,953
Miscellaneous Medical		-	-
Premiums Collected		-	(261,320)
Total Individual Plan		**$ 13,096,771**	**$ 4,774,388**
College Students-Service Costs		**$ 201,059**	**$ 77,126**
Total OHCA Program Costs		**$ 39,650,506**	**$ 31,091,229**
Administrative Costs			
Salaries	$ 73,467	$ 1,249,302	$ 1,322,769
Operating Costs	60,069	462,029	522,097
Health Dept-Postponing	-	-	-
Contract - HP	1,349,503	5,717,442	7,066,944
Total Administrative Costs	**$ 1,483,038**	**$ 7,428,773**	**$ 8,911,811**
Total Expenditures			**$ 40,003,041**
NET CASH BALANCE	**$ 1,498,834**		**$ 3,101,717**

Agenda

SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2016, For the Seven Month Period Ending January 31, 2016

REVENUES	FY 16 Revenue	State Share
Tobacco Tax Collections	$ 484,654	$ 484,654
TOTAL REVENUES	**$ 484,654**	**$ 484,654**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 7,414	$ 1,021	
Inpatient Hospital	1,248,100	171,863	
Outpatient Hospital	1,960,558	269,969	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	5,863	807	
Physicians	3,164,617	435,768	
Dentists	10,012	1,379	
Mid-level Practitioner	334	46	
Other Practitioners	3,696	509	
Home Health	5,132	707	
Lab & Radiology	224,288	30,885	
Medical Supplies	21,220	2,922	
Clinic Services	91,982	12,666	
Ambulatory Surgery Center	8,322	1,146	
Prescription Drugs	970,288	133,609	
Transportation	25,152	3,463	
Miscellaneous Medical	508	70	
Total OHCA Program Costs	**$ 7,747,486**	**$ 1,066,829**	
OSA DMHSAS Rehab	$ 44,560	$ 11,759	
Total Medicaid Program Costs	**$ 7,792,046**	**$ 1,078,588**	
TOTAL STATE SHARE OF COSTS			**$ 1,078,588**

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.

Agenda

OHCA MEDICAL ADVISORY COMMITTEE

SoonerCare Operations Update

OHCA Board Meeting April 28, 2016 (February 2016 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment February 2016	Children February 2016	Adults February 2016	Enrollment Change	Total Expenditures February 2016	PMPM February 2016	February 2016 Trend PMPM
SoonerCare Choice Patient-Centered			**528,179**	**434,059**	**94,120**	**4,633**	**$150,218,036**		
	Lower Cost	*(Children/Parents; Other)*	483,946	420,059	63,887	4,455	$108,165,469	$224	$204
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	44,233	14,000	30,233	178	$42,052,567	$951	$1,000
SoonerCare Traditional			**232,310**	**86,533**	**145,777**	**-3,062**	**$184,319,773**		
	Lower Cost	*(Children/Parents; Other)*	120,849	81,525	39,324	-3,089	$45,812,689	$379	$333
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS*	111,461	5,008	106,453	27	$138,507,084	$1,243	$1,231
SoonerPlan			**35,700**	**2,946**	**32,754**	**-301**	**$269,625**	$8	$7
Insure Oklahoma			**19,321**	**569**	**18,752**	**89**	**$6,837,151**		
	Employer-Sponsored Insurance		15,302	370	14,932	3	$5,163,921	$337	$279
	Individual Plan		4,019	199	3,820	86	$1,673,231	$416	$442
TOTAL			**815,510**	**524,107**	**291,403**	**1,359**	**$341,644,586**		

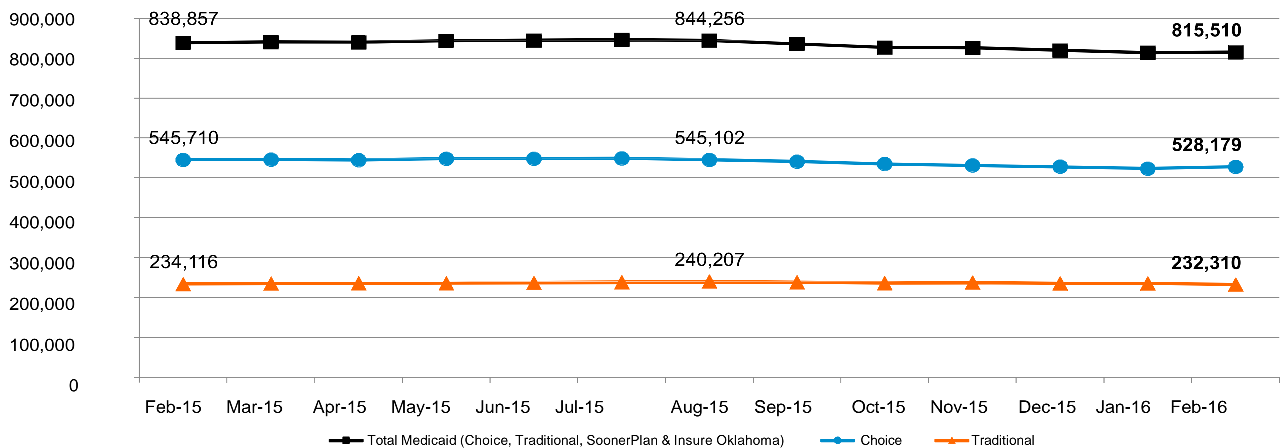
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

Total In-State Providers: 34,065 (-251) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

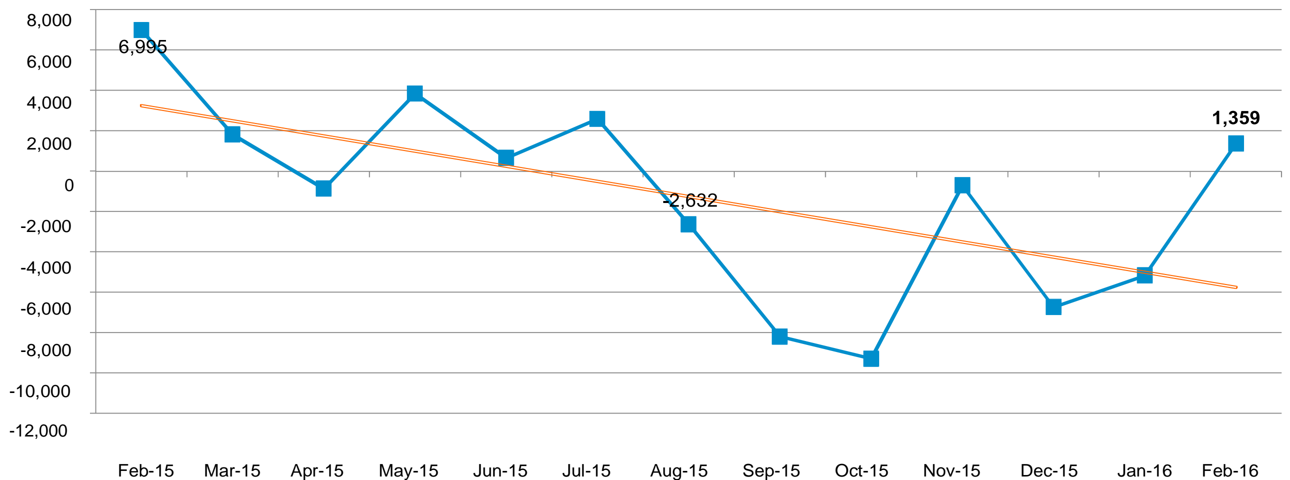
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,813	949	1,220	198	5,470	644	238	6,429	2,510

*Decrease in Total Provider count is due to Physician Assistant renewal starting in Feb 2016. Decrease during contract renewal period is typical during all renewal periods.

ENROLLMENT BY MONTH



MONTHLY CHANGE IN ENROLLMENT



Presentation, Discussion, and Vote on Proposed Rule Changes

May 2016 MAC

Proposed Rule Amendment Summaries

SUMMARY: 16-07 ADvantage Waiver — The proposed policy revisions eliminate coverage for Speech and Language services rendered in the Advantage Waiver, due to lack of utilization.

Budget Impact: Budget neutral

16-07 Advantage Waiver:

Services included in the ADvantage Program are:

(1) **Case management.**

(A) Case management services assist a member in gaining access to medical, social, educational, or other services, regardless of payment source that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services 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 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. 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, helps the member transition from institution to home by updating the service plan, and preparing services to start on the date the member is discharged from the institution. Case managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. 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 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 activities described as:

(i) any task or function 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 activities, such as clerical tasks including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities that are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

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

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

(ii) Very rural/difficult service area rate: Case management services are billed using a very rural/difficult service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than 25 persons per square mile. Exceptions are services to members who reside in Oklahoma Department of Human Services Aging Services (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 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. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan 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.

(B) In-home respite services are billed per 15-minute 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 is filed for a per diem rate when provided in a nursing facility. Extended respite must be at least eight hours in duration.

(D) In-home extended respite is filed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(3) **Adult day health care.**

(A) Adult day health care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the optimal functioning. Physical, occupational, and speech therapies are only provided as an enhancement to the basic adult day health care service when authorized by the service plan and are billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Personal care service enhancement in adult day health care is assistance in bathing, hair care, or laundry service, authorized by the service plan and billed as separate procedures. Most assistance with activities of daily living (ADL), such as eating, mobility, toileting, and nail care are integral services to adult day health care service and are covered by the 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 service is authorized when an ADvantage 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 is a 15-minute unit of service. No more than 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.

(C) Adult day health care therapy enhancement is a maximum of one session unit per day of service.

(D) Adult day health personal care enhancement is a maximum of one unit per day of bathing, hair care, or laundry service.

(4) **Environmental modifications**.

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

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the service plan that enable members to increase his or her ability to perform ADLs, or to perceive,

control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment necessary 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 not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping 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 have prior authorization.

(6)**Advanced supportive/restorative assistance**.

(A)Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B)Advanced supportive/restorative assistance service is billed per 15-minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the service plan that are within the scope of the Oklahoma Nursing Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice in the 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 works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or 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 reimbursable under either Medicaid or the Medicare Home Health Program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the service plan. A nursing assessment/evaluation, on-site visit is made to each member for whom advanced supportive/restorative assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report is made to the ADvantage Program case manager in accordance with review schedule determined between the case manager

and 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 services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of the:

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

(II) 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 rules and regulations for the delegation of nursing tasks established by the Oklahoma Board of Nursing.

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

(I) prepare a one-week supply of insulin syringes for a person who is blind and has diabetes, who can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;(II) 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) 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) provide nail care for the member with diabetes or member who has circulatory or neurological compromise;

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

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's service plan development and/or assessment/evaluation, 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, another procedure code is used to bill for all other authorized nursing services. A maximum of eight units per day of nursing for 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 Medicaid in-home care

services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied 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.**

(A) Skilled nursing services listed in the service plan that are within the scope of the state's Nurse Practice Act and are ordered by a licensed physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by an RN, or an LPN or LVN under the supervision of a registered nurse, licensed to practice in the state. Skilled 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. 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. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per 15-minute units of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's service plan.

(9) **Home delivered meals.**

(A) Home delivered meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one-third of the 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 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 in accordance with the member's service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment, and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

(A) Occupational therapy services are 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, 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 limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(11) **Physical therapy services.**

(A) Physical therapy services are those services that 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 limitations of 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 when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

~~(12) **Speech and language therapy services.**~~

~~(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/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, or development, and oversight of a therapeutic maintenance program. Under a physician's order, a~~

~~licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes Speech Language Pathology Assistant services within the limitations of his or her practice, working under the supervision of the licensed Speech and Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The Speech and Language Pathologist ensures monitoring and documentation of the member's rehabilitative progress and 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 and language therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.~~

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

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six months or less, and orders hospice care. ADvantage hospice care is authorized for a six-month period, and requires physician certification of a terminal illness and orders of hospice care. 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 30-calendar days prior to the initial hospice authorization end date, and re-certify that the member has a terminal illness, has six months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of 60-calendar day increments with physician certification that the member has a terminal illness and six months or less to live. A member's service plan that includes hospice care must comply with Waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care 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 illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(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.

(D) Hospice services are billed per diem of service for days covered by a hospice plan of care and 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 care within a 12-month period is limited to an amount equivalent to 85percent of the Medicare hospice cap payment, and must be authorized on the member's service plan.

~~(14)~~(13) **ADvantage personal care.**

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

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager are responsible for the development and monitoring of the member's personal care services.

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

~~(15)~~(14) **Personal emergency response system.**

(A) Personal emergency response system (PERS) is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all of the 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 member from getting up unassisted from a fall;

(ii) member lives alone and 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 ensure the member's health and safety in 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. All services are prior-authorized in accordance with the ADvantage approved service plan.

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

(A) CD-PASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enable a member in need of assistance to reside in their home and 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 PSA and the APSA. The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

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

(ii) is solely responsible to provide instruction and training to the PSA or APSA on tasks and works with the consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an 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 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 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 services the PSA may provide include:

(i) assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or 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 home services that may include shopping, laundry service, cleaning, and seasonal chores;

(iv) companion 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, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the service plan.

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, 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 member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who when appropriate, order home health services. 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, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

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

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

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

(v) using a lift for transfers;

(vi) manually assisting with oral medications;

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

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

(ix) using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by DHS AS. 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;

(iii) responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSAs or APSAs on the member/employer's behalf;

(iv) 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) making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The 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.

(F) The 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.

~~(17)~~(16) **Institutional transition services.**

(A) Institutional transition services are those services necessary to enable ~~an~~a member to leave the institution and receive necessary support through ADvantage Waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's service plan that are necessary to ensure the health, welfare, and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed Waiver and other State plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. 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 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. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by DHS AS to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) 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 per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish transitional case management services from regular case management services.

(C) Institutional transition services may be authorized and reimbursed per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institutional transition services are provided to the member within 180 calendar-days of discharge from the institution.

(iv) services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institutional transition services but fails to enter the Waiver, any institutional transition services provided are not reimbursable.

~~(18)~~(17) **Assisted living services.**

(A) Assisted living services (ALS) are personal care and supportive services furnished to Waiver members who reside in a homelike, non-institutional setting that includes 24-hour, on-site response capability to meet scheduled or unpredictable 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 law. The 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 ALS. ADvantage reimbursement for 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 as determined through the individualized assessment and documented on the member's service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The 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 emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (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 member with other residents;

(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 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 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, the member, 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, 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 is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed 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 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 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 members with Alzheimer's disease and related dementias, physical disabilities, or other special needs 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) When the provider arranges and coordinates services for members, the provider is obligated to assure the provision of those services.

(viii) 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 ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive service plan. The Advantage case manager in cooperation with 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) Placement, or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the 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 interfere with the rights or well-being of other residents and the ALC has documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ALC attempted interventions to resolve behavior problems.

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

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

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member and/or the member's representative, if any, the AA and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, 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 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 an appropriate care provider. The 30 calendar-day requirement 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. 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;

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

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

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

(D) ADvantage 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 an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit Keys to rooms may be held by appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. 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.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the member and that preserves 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.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage 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 areas, of 360 square feet.

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

(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.

(VII) The member is responsible for furnishing 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 member supplied furnishings pose a health or safety risk, the member's 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.

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

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the

member in compliance with the Americans with Disabilities Act accessibility guidelines per 28 Code of Federal Regulations, Part 36, Appendix A, at no additional cost to the member.

(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.

(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.

(XIII) The ALC must be physically accessible to members.

(ii) Sanitation.

(I) The ALC must maintain the facility, including its individual rental units that 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, 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 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 members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

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

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious 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 members to safely evacuate in the event of fires or other emergencies.

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

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

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

(II) The ALC must ensure staffing is sufficient to meet the needs of the ADvantage Program members in accordance with each member's ADvantage service plan.

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

(v) Staff training and qualifications.

(I) The ALC must ensure staff 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 OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight hours of orientation and initial training within the first month of employment and at least four hours annually thereafter. Staff providing direct care on a dementia unit must receive four additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count 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 regulations including, but not limited to, the Oklahoma Nurse Practice Act and 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 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 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 Member Assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that 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 member, the member's representative, or the legal guardian. The ALC must ensure 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 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 ALC are those defined by OSDH 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 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 be submitted via facsimile or mail to the member's ADvantage case manager and to the AA. The follow up report must be submitted within five business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed 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, DHS Adult Protective Services (APS) as soon as the person is aware of the situation per O.S. 43A ' 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at the minimum, include who, what, when, 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. The final report at 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. 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 for delivery of necessary health services. The Advantage case manager is responsible for monitoring 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) ALS are billed per diem of service for days covered by the ADvantage member's service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage assisted living services for a member is one of three per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, IADLs, and health care needs. The rate level is based on the Universal Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

Agenda

Informational Items Only

Access Monitoring Review Plan

http://okhca.org/xPolicyChange.aspx?id=18967&blogid=68505

Access Monitoring Review Plan 2016

Submitted to CMS: XX/XX/2016

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Agenda

2017-2018 SoonerCare Choice and Insure Oklahoma 1115(a) Demonstration Waiver Extension Request – Pursuant to 42 CFR §431.408, the Oklahoma Health Care Authority (OHCA) is providing notice of its plan to submit an update to its current renewal application for the SoonerCare Choice and Insure Oklahoma 1115(a) waiver to the Centers for Medicare and Medicaid Services (CMS). The OHCA is requesting an additional two year extension of the waiver for the period January 1, 2017, to December 31, 2018. The OHCA welcomes comments on the continuation of the SoonerCare Choice and Insure Oklahoma programs. The existing waiver application is currently posted on the OHCA website. It can be found on the Policy Change Blog and the Native American Consultation Page. The OHCA will be accepting comments/feedback for the waiver application until June 3, 2016.

Agenda