Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

November 16th, 2017
1:45 PM – 3:30 PM

Charles Ed McFall Board Room

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

II. Action Item: Approval of Minutes for the amended July 20th, 2017: **Medical Advisory Committee Meeting**
Action Item: Approval of Minutes for the September 21st, 2017: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

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

VI. SoonerCare Operations Update: **Casey Dunham, Director of Provider Services**

- **A.** TSET Update: **Della Gregg, Population Care Management; Kelly Parker, SoonerQuit Health Promotion Supervisor**

VII. Legislative Update: **Cate Jeffries, Interim Legislative Liaison**

VIII. Special Recognition: **Tywanda Cox, Director of Policy and Planning**

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

- **A.** 17-10A Expedited Appeals Revisions
- **B.** 17-10B Notification Policy Revisions
- **C.** 17-12 Wage Enhancement Policy Revisions
- **D.** 17-18 Therapeutic Leave Days Revisions

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

XI. Discussion Items Only: **Demetria Bennett, Policy Development Coordinator**

- **A.** Nursing Facility Supplemental Payment Program

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

- **A.** Election of Chairman and Co-Chairman

XIII. Future Meeting:

January 18th, 2018
March 15th, 2018
May 17th, 2018
July 19th, 2018
September 20th, 2018
November 15th, 2018

XIV. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the July 20th, 2017 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions:

Co-Chairman Steve Goforth called the meeting to order at 1:00 PM.

***Delegates present were*:** Ms. Renee Banks, Ms. Teresa Bierig, Ms. Debra Billingsley, Dr. Joe Catalano, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Terrie Fritz, Mr. Steve Goforth, Mr. Mark Jones, Dr. Ashley Orynich, Ms. Annette Mays, Mr. Victor Clay, Dr. J. Daniel Post, Ms. Carrie Slatton-Hodges,Mr. Edd Rhoades, Mr. Rick Snyder, Mr. Jeff Tallent, and Dr. John Linck.

Alternates present were: Dr. Mike Talley and providing a quorum.

***Delegates absent without an alternate were*:** Ms. Mary Brinkley, Mr. Brett Coble, Dr. Steven Crawford, Mr. James Patterson, Ms. Toni Pratt- Reid, Dr. Jason Rhynes, and Dr. Kanwal Obhrai.

II. Approval of May 18th, 2017 Minutes

Medical Advisory Committee

Co-Chairman Goforth did a call to vote to approve the meeting minutes for May 18th, 2017.
It was motioned by Dr. John Linck and Mr. Jeff Tallent seconded the motion. All members voted to approve the minutes.

III. Public Comments (2 minute limit)

Mr. Richard Desirey commented about serving children in need of treatment. He believes that a community which mobilizes with stakeholders, that are families, persons being served, representatives of varied agencies, state, local, nonprofit and with minority community representative should be able to form a systems of care in a strength base.

Ms. Lola Edwards commented on her concerns for the 49 payments that are planned for the 2018 budget instead of the 52 weeks. They represent the advantage program providers, who have already been cut by DHS to the total of 9.2 million dollars.

Ms. Joy Sloan with CMHC's which serves all 77 counties across the state is asking to reluctantly support the reduction of case management services.

IV. MAC Member Comments

Ms. Anette Mayes asked why the payments are being held three weeks on the advantage program.

Ms. Tasha Black responded to her question. There are two reasons for the delay; Reason one being the loss in F-MAP/ CHIP which amounted to 50 million dollars in revenue. We were also short 34 million dollars in our state appropriation dollars. One cycle is being bumped as a result of the 34

million shortfalls. The other 50 million represents two weeks. If CHIP is reauthorized we are looking at delaying only one payment cycle.

V. Financial Update:

Gloria Hudson, Director of General Accounting

Ms. Gloria Hudson reported on the state's Fiscal Year 2017 financial transactions through the month of April. She reported that the state budget variance is a positive $10.6 million dollars. On the expenditure side, Medicaid Program is under budget by 6 million state dollars and in administration $4 million state dollars. On the revenue side, OHCA is over budget $1.8 million state dollars in Drug Rebates and Collections. Settlements and Overpayments are under budget $0.1million state dollars and in Tobacco Tax Collections are negative $1.1 million state dollars.

A. **2018 Budget update:**

MS. Tasha Black reported on the 2018 Budget Work Program. The state officially appropriated $1,025,516,034 for the state fiscal 2018 budget. The appropriation consists of $903 million in general revenue and special cash. $12 million from the tobacco settlement fund, $70 million from the Health Care Enhancement Fund, $32 million in the rainy day funds, a $3 million transfer from the Health Employee and Economy Improvement Act revolving fund and $ 6 million from our Fund 200 revolving fund. In addition to the appropriated dollars we have been authorized to transfer $30 million from the supplemental hospital offset payment fund.

The increases in the appropriations were unable to support the agency's total need. In an effort to balance the current years' budget, we opted to delay that last 3 cycles in June until FY 19. Two of the cycles represent the loss of federal funds associated with the drop in FMAP for Children's Health Insurance Program roughly, $50 million also known as CHIP. The other cycle enables us to continue to maintain the program at the current level. We remain optimistic that CHIP will be reauthorized and will file a revised budget at the time we will reduce the delayed payment cycle to one.

Managed Care's actual projected growth rate is 8.2%. Much of the growth is attributed to the increased enrollment in the Program known as PACE, which is up by 30%. The hospital category increased by 4% as the result of the approval of the new drug Spinraza. We are budgeting an additional $43 million dollars for prescription drugs, which is an increase of 8%. Medicare rates are set by CMS and reassessed yearly in January, which we have no control over the cost. We have seen a 10% increase in rates over the last two years with an impact in FY 18 of 9.3 million. For more detailed information please see item 5A in the full agenda packet.

VI. Legislative Update:

Austin Marshall, Director of Governmental Affairs

Mr. Marshall stated that we now have a budget but unfortunately it is about $34 million short from what we had asked for. We will delay the last week's payment for June 2018; the other two are tied to whether or not CHIP will be reauthorized. $70 million is tied to the cigarette fee, which is currently being ligated in the Oklahoma Supreme Court, which is currently scheduled to be argued in front of the Supreme Court August 8th at 10:00AM. Mr. Goforth stated that it was time for a long term sustainable budget, as the medical professions here take care of the safety net for very vulnerable people. Mr. Marshall commented that this was the third year in a row with revenue shortage.

VII. SoonerCare Operations Update:

Melinda Thomason, Director of Health Care Systems Innovation

Ms. Thomason presented the SoonerCare Operations Update to the committee. She presented information based on data for May of 2017. Patient Centered Medical Home enrollment is at 70% of total SoonerCare eligibility, which is 551,829. Sooner Care Traditional has a current enrollment of 236,214, Insure Oklahoma has a total enrollment of 19,612, and SoonerPlan enrollment is at 34,520. In total, SoonerCare enrollment is at 842,175 for May .Total In-State providers are up by 192, giving a total of 34,736. Dual enrollees are up at 14% of membership. Long term care individuals are at 14,904. To compare adult and child groups, SoonerCare Choice children are 65% of our enrollment at 455,112. Our Traditional adults follow at 146,998, SoonerCare choice adults are at 96,717 and 89,216 are Traditional children who are not enrolled in a patient centered medical home.

A. Fast Facts Update:

Andy Garland, Reporting manager

Mr. Garland provided an update for our reports posted on our external website. Data is available for expenditures and members by county, Expenditures and Members by Legislator, Historic category of member services and expenditures, SoonerCare and Insure Oklahoma members by age, and SoonerCare monthly enrollment 2006 to present. Fast facts allow you to view enrollment by the total number, county, children, adults, race, TEFRA, and PACE.

VIII. Proposed Rule Changes:

Demetria Bennett, Policy Development Coordinator

A face to face tribal consultation regarding the following proposed changes was held Tuesday, May 23rd, 2017 and Tuesday, July 11, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA).

Rule changes within work folders 17-05 A&B and 17-06 were posted on the OHCA public website for a comment period from June 15, 2017 through July 14, 2017. Rule changes within work folder 17-09 will be posted on the OHCA public website for comments through July 28, 2017.

17-05 A&B Medical Identification Card Policy Revisions — the proposed revisions remove references that refer to the issuing/mailing of member medical identification cards. This policy change is the result of the Oklahoma Health Care Authority no longer printing and/or issuing plastic cards. Members now have access to print their medical identification card from their online member account, or non-online enrollment members can visit their local county Oklahoma Department of Human Services (OKDHS) office to obtain a printed card. Providers can verify the member's eligibility online via the Eligibility Verification System. Additionally, revisions update language to reflect how the OKDHS notifies members of eligibility and ineligibility determinations for medical services by mailing out computer-generated notification forms. Finally, the policy revisions update the language for the medical and financial certification processes for the OKDHS ADvantage program.
Budget Impact: Revisions to medical identification cards will result in a total budget savings of $96,000 (CY).
The rule change motion to approve was by Dr. Joe Catalano and seconded by Mr. Jeff Tallent and passed unanimously.

17-06 Pharmacy Revisions — the proposed pharmacy revisions remove coverage of optional non-prescription drugs for adults. (Insulin, nicotine replacement products for smoking cessation, and family planning products are not optional.) Additionally, compounded prescriptions for topical use will require a prior authorization for allowable cost exceeding a pre-determined limit. Finally, revisions cleanup language by correcting the number of prescriptions allowed for adults receiving services under the 1915(c) Home and Community-Based Services Waivers from two (2) to three (3), which will align with current practices.
Budget Impact: Revisions that remove coverage of optional non-prescription drugs for adults will result in a total budget savings of $825,000 for SFY 2018; state share $338,992.50; federal share $486,007.50.
The rule change motion to approve was by Dr. Joe Catalano and seconded by Ms. Carrie Slatton-Hodges and passed unanimously.

17-09 Behavioral Health Case Management Limits — the proposed Behavioral Health Targeted Case Management (TCM) revisions establish yearly limits on the amount of basic case management/resource coordination that is reimbursable by SoonerCare on a fee-for-service basis. The current limit of twenty-five (25) units per member per month basic case management/resource coordination will be reduced to sixteen (16) units per member per year. A process for authorizing up to twenty-five (25) units per member per month will be used for individuals who demonstrate the medical need for additional units. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2018 in order to meet the balanced budget requirements as mandated by state law. Without the recommended revisions, the Department

is at risk of exhausting its state appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.

Budget Impact: Estimated savings to ODMHSAS for SFY 2018 is $8,447,984 Total; $3,500,000 state share.

The motion was to approve the rule change was by Mr. Jeff Tallent and seconded by Dr. Joe Catalano. The rule change was approved with one vote opposing, from Ms. Annette Mays.

Ms. Annette Mays asked to hear a little bit of background on how this came out and why this change makes sense as opposed to some others.

Mr. Traylor Rains-Sims responded that was left with a 3.5 million dollar shortfall, primarily due to the drop of the FMAP. There are two types of case management; this is the basic resource coordination level. There is also an intensive care case management, which is delivered primarily through programs of assertive community treatment, which is a community based team approach of working with adults with serious mental illness. Health homes are available in the state that works with adults with SMI and children SED who uses the systems of care model. On average children are only getting 48 a year even though we authorize up to 25 a month, and adults are getting 26.

IX. Discussion Items Only:

Concern over the concept of a two year budget was brought to discussion. Changes in state level would have to be made; budgeting process is determined by both chambers of legislature, who don't seem interested in changing up the order of business.

A request was made to consider recommending a long term budget to the senate. If this is a route that wants to be taken, it needs to be an agenda item for the next meeting, as guidelines will need to be reviewed.

X. Future Meeting

September 21st, 2017

XI. Adjournment

Mr. Goforth adjourn the meeting

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the September 21st, 2017 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions:

Chairman Steven Crawford called the meeting to order at 1:00 PM.

***Delegates present were*:** Ms. Renee Banks, Ms. Teresa Bierig, Ms. Debra Billingsley, Ms. Mary Brinkley, Dr. Joe Catalano, Mr. Victor Clay, Mr. Brett Coble, Dr. Steve Crawford, Ms. Wanda Felty, Dr. Don Flinn, Dr. Arlen Foulks, Ms. Terrie Fritz, Mr. Mark Jones, Ms. Annette Mays, Dr. Ashley Orynich, Dr. J. Daniel Post, Ms. Toni Pratt-Reid, Dr. Edd Rhoades, Dr. Jason Rhynes, Dr. Dwight Sublett, Mr. Rick Snyder, and Mr. Jeff Tallent.

Alternates present were: Dr. Lori Holmquist- Day and Mr. Traylor Rains-Sims

***Delegates absent without an alternate were*:** Mr. Steve Goforth and Dr. Paul Wright

II. Approval of July 21st, 2017 Minutes

Medical Advisory Committee

Chairman Crawford discussed the meeting minutes for July 21st, 2017. These will be corrected and brought back for approval during the November MAC Meeting. Motion made and seconded. Approved.

III. Public Comments (2 minute limit)

Mr. Brent Siemens made a comment about proposed budget cuts. He asked that if cuts are made on capitation payments for Care Coordination, cuts should be spread evenly across all providers, not just to reduce payments to PCPs.

IV. MAC Member Comments

Dr. Steven Crawford commented that the MAC will now follow the OHCA Board Meeting rules regarding the public comments. We will set up an email address for individuals to send notice that they wish to speak or send comments in writing. We will hear from the first 15 people who sign up. Comments will be limited to two minutes per person. We will put all requests on a list and monitor that, as some individuals may not actually show up to speak.

V. Financial Update:

Gloria Hudson, Director of General Accounting

Ms. Gloria Hudson reported on the state's Fiscal Year 2017 financial transactions through the month of June. She reported that the state budget variance is a positive $12 million dollars. On the expenditure side, Medicaid Program is positive $14.9 million state dollars and in administration $8.4

million state dollars. On the revenue side, OHCA is positive $6.3 million state dollars in Drug Rebates and Collections while Settlements and Overpayments are positive $2.3 million state dollars.

A. **2018 Budget update:**
Ms. Evans presented on SFY 2018. She presented a document that has been prepared in the event we receive a budget failure for 2018. For more detailed information please see item 5A in the full agenda packet.

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

Ms. Asmussen presented the SoonerCare Operations Update to the committee. She presented information based on data for June of 2017. Patient Centered Medical Home enrollment is at 545,858 which is 5,971 less than May. Sooner Care Traditional has a current enrollment of 234,331 which is 1,883 less than May. SoonerPlan is down by 1,025, giving a total of 33,495. Insure Oklahoma has a total enrollment of 19,517 of which 5,068 are in the Individual Plan and 14,449 are in the Employee Sponsored Plan. In total, SoonerCare enrollment is at 833,201 for June which is a decrease of 8,974.

A. Focus Forward Oklahoma Program Update:
Mary Gowin, LARC Coordinator

Ms. Gowin spoke about the Focus Forward Oklahoma Mission to decrease unintended pregnancies in Oklahoma by increasing access to and utilization of long-acting reversible contraception (LARC). For more detailed information please see item 6A in the full agenda packet.

B. Member Audits:
Ginger Clayton, Member Audits Manager

Ms. Clayton provided a member audit update which includes: primary investigative functions, Primary audits functions, information referrals, the common types of referrals, screening and assignment and moving forward. For more detailed information please see item 6B in the full agenda packet.

VII. Legislative Update:
Cate Jeffries, Interim Legislative Liaison

Ms. Jeffries provided an update on the Federal Children's Health Insurance Program which is set to expire September 30th. The US senate introduced a funding bill that would authorize funding until 2022. The bill is called Keeping Kids Insurance Dependable and Secure for Kids Act.

VIII. Proposed Rule Changes:

Tywanda Cox, Chief of Federal and State Policy

A face-to-face tribal consultation regarding the following proposed changes was held on Tuesday, September 5, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA).

APA work folder 17-03 was posted on the OHCA public website for a comment period from August 14, 2017 through September 13, 2017. APA work folder 17-13 was posted on the OHCA public website for a comment period from August 30, 2017 through September 21, 2017. APA work folder 17-14 was posted on the OHCA public website for a comment period from September 6, 2017 through September 21, 2017

17-03 Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/Us) Reimbursement Outside of Four Walls — the proposed revisions will allow I/T/Us, who are designated as Federally Qualified Health Centers, to be reimbursed at the Office of Management and Budget rate for services provided outside of the four walls of their facilities. These changes are necessary to comply with federal regulations.

Budget Impact: Budget neutral

The rule change motion to approve was by Dr. Joe Catalano and seconded by Mr. Traylor Rains-Sims and passed unanimously.

17-13 Signature Requirements Revisions — the proposed revisions will clarify the authentication of electronic medical records. Current policy that became effective September 1, 2017 requires that the record be authenticated within three (3) days of the provision of the underlying service. New revisions will revert the three (3) day signature language to the policy that was in place on June 25, 2011. The proposed revisions will clarify that the authentication of medical records is expected on the day the record is completed. Additionally, revisions will describe that the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed if the record is being transcribed.

Budget Impact: Budget neutral

The rule change motion to approve was by Ms. Annette Mays and seconded by Mr. Rick Snyder and passed unanimously.

17-14 Adult Dental Emergency Extractions — The proposed revisions will clarify dental coverage for adults by amending the rule that limits dental services for adults to "emergency" extractions. The policy was initially intended for emergency extractions and was later revised to medically necessary extractions. The intent of the change was to ensure the emergency extractions were medically

necessary; therefore, the policy will revert back to the original language to include the term emergency along with reference to where emergency dental care is defined in policy. Additionally, the proposed revisions will add new language on the medically necessary images and oral examination that can accompany an emergency extraction**.**

Budget Impact: Revisions for clarifying dental coverage for adults will result in approximately $479,017 of state share savings for eight months of SFY 2018. Additionally, the proposed revision is an effort to not exhaust additional dollars to services that were not intended to be covered. The rule change motion to approve was by Ms. Tony Pratt-Reid and seconded by Mr. Jeff Tallent and passed unanimously.

IX. 1115 Demonstration Renewal & Post Award Forum

Sherris Harris- Ososanya, Waiver Development Coordinator

Ms. Harris- Ososanya discussed that 2019-2021 renewal application and post award forum .We maintain our major objectives to improve access to preventive primary care services, to provide each member with a medical home, and to integrate Indian health services, eligible beneficiary and tribal providers into the SoonerCare delivery systems. Additional objectives are to expand access to affordable health insurance for low income working adults and their spouses, as well as to optimize quality of care through effective care management. Three primary programs are operated through the 1115 waiver. These are the Patient-Centered Medical Homes, the Health Management Program and the Health Access Network (HANS).

X. New Business:

There was no new business to discuss

XI. Future Meeting

November 16th, 2017

XII. Adjournment

Dr. Crawford asked for a motion to adjourn. Motion was provided by Ms. Terri Fritz and seconded by Mr. Jeff Tallent. There was no dissent and the meeting was adjourned at 2:47p.m.

FINANCIAL REPORT

For the Three Months Ended September 30, 2017
Submitted to the CEO & Board

- Revenues for OHCA through September, accounting for receivables, were **$1,101,117,955** or **.4% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,011,924,747 or .5% under** budget.
- The state dollar budget variance through September is a **positive $556,763.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(2.0)
Administration		1.2
Revenues:		
Drug Rebate		.0
Taxes and Fees		1.4
Overpayments/Settlements		.0
Total FY 18 Variance	**$**	**.6**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2018, For the Three Month Period Ending September 30, 2017

REVENUES	FY18 Budget YTD	FY18 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 301,330,548	$ 301,330,548	$ -	0.0%
Federal Funds	571,323,294	565,213,294	(6,110,000)	(1.1)%
Tobacco Tax Collections	12,502,751	13,981,260	1,478,509	11.8%
Quality of Care Collections	19,754,144	19,700,977	(53,167)	(0.3)%
Prior Year Carryover	39,249,967	39,249,967	-	0.0%
Federal Deferral - Interest	67,286	67,286	-	0.0%
Drug Rebates	85,241,953	85,308,519	66,566	0.1%
Medical Refunds	8,535,694	8,535,694	0	0.0%
Supplemental Hospital Offset Payment Program	60,407,861	60,407,861	-	0.0%
Other Revenues	7,308,547	7,322,549	14,002	0.2%
TOTAL REVENUES	**$ 1,105,722,044**	**$ 1,101,117,955**	**$ (4,604,089)**	**(0.4)%**

EXPENDITURES	FY18 Budget YTD	FY18 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 13,929,006**	**$ 12,666,252**	**$ 1,262,754**	**9.1%**
ADMINISTRATION - CONTRACTS	**$ 27,289,614**	**$ 25,689,669**	**$ 1,599,945**	**5.9%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	11,241,086	10,807,399	433,687	3.9%
Acute Fee for Service Payments:				
Hospital Services	226,433,028	227,322,422	(889,394)	(0.4)%
Behavioral Health	5,010,038	5,091,849	(81,811)	(1.6)%
Physicians	94,958,331	94,273,449	684,882	0.7%
Dentists	31,471,778	32,201,455	(729,677)	(2.3)%
Other Practitioners	13,730,498	13,658,326	72,172	0.5%
Home Health Care	4,199,101	4,262,987	(63,886)	(1.5)%
Lab & Radiology	7,935,651	6,996,990	938,661	11.8%
Medical Supplies	12,344,397	12,248,830	95,567	0.8%
Ambulatory/Clinics	49,090,396	47,096,195	1,994,201	4.1%
Prescription Drugs	142,226,186	142,178,279	47,907	0.0%
OHCA Therapeutic Foster Care	3,000	751	2,249	0.0%
Other Payments:				
Nursing Facilities	137,126,332	136,698,064	428,268	0.3%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	15,433,262	15,182,604	250,658	1.6%
Medicare Buy-In	43,164,446	43,323,623	(159,178)	(0.4)%
Transportation	16,237,447	16,054,480	182,967	1.1%
Money Follows the Person-OHCA	59,202	76,291	(17,089)	0.0%
Electonic Health Records-Incentive Payments	3,310,174	3,310,174	-	0.0%
Part D Phase-In Contribution	26,846,908	27,032,741	(185,833)	(0.7)%
Supplemental Hospital Offset Payment Program	132,311,447	132,311,447	-	0.0%
Telligen	2,644,890	3,440,470	(795,580)	(30.1)%
Total OHCA Medical Programs	**975,777,597**	**973,568,826**	**2,208,771**	**0.2%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,017,085,599**	**$ 1,011,924,747**	**$ 5,160,852**	**0.5%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 88,636,445**	**$ 89,193,208**	**$ 556,763**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2018, For the Three Month Period Ending September 30, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 10,839,454	$ 10,804,220	$ -	$ 32,055	$ -	$ 3,178	$ -
Inpatient Acute Care	318,362,982	151,868,268	121,672	783,230	98,870,820	193,570	66,525,422
Outpatient Acute Care	101,728,698	74,349,179	10,401	1,052,740	25,537,046	779,332	-
Behavioral Health - Inpatient	13,733,100	3,087,108	-	94,273	7,574,695	-	2,977,024
Behavioral Health - Psychiatrist	2,333,626	2,004,740	-	-	328,886	-	-
Behavioral Health - Outpatient	3,770,357	-	-	-	-	-	3,770,357
Behaviorial Health-Health Home	12,584,730	-	-	-	-	-	12,584,730
Behavioral Health Facility- Rehab	69,347,209	-	-	-	-	16,684	69,347,209
Behavioral Health - Case Management	3,606,617	-	-	-	-	-	3,606,617
Behavioral Health - PRTF	14,535,818	-	-	-	-	-	14,535,818
Behavioral Health - CCBHC	14,660,325	-					14,660,325
Residential Behavioral Management	4,151,574	-	-	-	-	-	4,151,574
Targeted Case Management	17,497,372	-	-	-	-	-	17,497,372
Therapeutic Foster Care	751	751	-	-	-	-	-
Physicians	110,772,919	93,124,274	14,525	1,166,152	-	1,134,650	15,333,317
Dentists	32,213,004	32,199,357	-	11,549	-	2,098	-
Mid Level Practitioners	613,808	609,459	-	4,104	-	246	-
Other Practitioners	13,175,577	12,907,242	111,591	126,956	-	29,789	-
Home Health Care	4,264,192	4,262,162	-	1,205	-	825	-
Lab & Radiology	7,195,124	6,936,812	-	198,134	-	60,178	-
Medical Supplies	12,340,307	11,564,675	677,883	91,476	-	6,272	-
Clinic Services	48,468,353	45,423,385	-	307,363	-	42,381	2,695,223
Ambulatory Surgery Centers	1,670,611	1,629,086	-	40,182	-	1,343	
Personal Care Services	2,841,288	-	-	-	-	-	2,841,288
Nursing Facilities	136,698,064	82,965,823	53,724,625	-	-	7,616	-
Transportation	16,056,938	15,417,066	583,660	27,952	-	28,260	-
GME/IME/DME	88,591,999	-	-	-	-	-	88,591,999
ICF/IID Private	15,182,604	12,370,239	2,812,365	-	-	-	-
ICF/IID Public	5,577,613	-	-	-	-	-	5,577,613
CMS Payments	70,356,364	70,157,106	199,259	-	-	-	-
Prescription Drugs	145,238,942	141,529,437	-	3,060,663	-	648,842	-
Miscellaneous Medical Payments	25,495	23,980	-	-	-	1,515	-
Home and Community Based Waiver	49,914,993	-	-	-	-	-	49,914,993
Homeward Bound Waiver	19,629,151	-	-	-	-	-	19,629,151
Money Follows the Person	76,291	76,291	-	-	-	-	-
In-Home Support Waiver	6,173,766	-	-	-	-	-	6,173,766
ADvantage Waiver	43,080,877	-	-	-	-	-	43,080,877
Family Planning/Family Planning Waiver	1,324,113	-	-	-	-	-	1,324,113
Premium Assistance*	14,360,630	-	-	14,360,630	-	-	-
Telligen	3,440,470	3,440,470	-	-	-	-	-
Electronic Health Records Incentive Payments	3,310,174	3,310,174	-	-	-	-	-
Total Medicaid Expenditures	**$ 1,439,746,280**	**$ 780,061,304**	**$ 58,255,981**	**$ 21,358,664**	**$ 132,311,447**	**$ 2,956,778**	**$ 444,818,789**

* Includes $14,256,037.87 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2018, For the Three Month Period Ending September 30, 2017

REVENUE	FY18 Actual YTD
Revenues from Other State Agencies	$ 179,635,997
Federal Funds	272,790,892
TOTAL REVENUES	**$ 452,426,889**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	$ 49,914,993
Money Follows the Person	-
Homeward Bound Waiver	19,629,151
In-Home Support Waivers	6,173,766
ADvantage Waiver	43,080,877
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	5,577,613
Personal Care	2,841,288
Residential Behavioral Management	2,202,986
Targeted Case Management	15,471,597
Total Department of Human Services	**144,892,271**
State Employees Physician Payment	
Physician Payments	15,333,317
Total State Employees Physician Payment	**15,333,317**
Education Payments	
Graduate Medical Education	50,325,348
Graduate Medical Education - Physicians Manpower Training Commission	2,678,173
Indirect Medical Education	34,013,202
Direct Medical Education	1,575,276
Total Education Payments	**88,591,999**
Office of Juvenile Affairs	
Targeted Case Management	568,936
Residential Behavioral Management	1,948,587
Total Office of Juvenile Affairs	**2,517,523**
Department of Mental Health	
Case Management	3,606,617
Inpatient Psychiatric Free-standing	2,977,024
Outpatient	3,770,357
Health Homes	12,584,730
Psychiatric Residential Treatment Facility	14,535,818
Certified Community Behavioral Health Clinics	14,660,325
Rehabilitation Centers	69,347,209
Total Department of Mental Health	**121,482,080**
State Department of Health	
Children's First	386,807
Sooner Start	1,553,698
Early Intervention	1,045,849
Early and Periodic Screening, Diagnosis, and Treatment Clinic	431,680
Family Planning	61,680
Family Planning Waiver	1,255,455
Maternity Clinic	1,375
Total Department of Health	**4,736,544**
County Health Departments	
EPSDT Clinic	192,467
Family Planning Waiver	6,978
Total County Health Departments	**199,445**
State Department of Education	**-**
Public Schools	**24,184**
Medicare DRG Limit	**65,000,000**
Native American Tribal Agreements	**516,003**
Department of Corrections	**320,177**
JD McCarty	**1,205,245**
Total OSA Medicaid Programs	**$ 444,818,789**
OSA Non-Medicaid Programs	**$ 23,937,955**
Accounts Receivable from OSA	**$ 16,329,854**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2018, For the Three Month Period Ending September 30, 2017

REVENUES		FY 18 Revenue
SHOPP Assessment Fee	$	60,362,767
Federal Draws		79,307,481
Interest		36,451
Penalties		8,643
State Appropriations		(7,550,000)
TOTAL REVENUES	$	132,165,342

EXPENDITURES	Quarter		FY 18 Expenditures
Program Costs:	7/1/17 - 9/30/17		
Hospital - Inpatient Care	98,870,820	$	98,870,820
Hospital -Outpatient Care	25,537,046		25,537,046
Psychiatric Facilities-Inpatient	7,574,695		7,574,695
Rehabilitation Facilities-Inpatient	328,886		328,886
Total OHCA Program Costs	132,311,447	$	132,311,447
Total Expenditures		$	132,311,447

CASH BALANCE		
	$	(146,105)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2018, For the Three Month Period Ending September 30, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 19,691,923**	**$ 19,691,923**
Interest Earned	**9,055**	**9,055**
TOTAL REVENUES	**$ 19,700,977**	**$ 19,700,977**

EXPENDITURES	FY 18 Total $ YTD	FY 18 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 52,805,501	$ 21,153,884	
Eyeglasses and Dentures	67,524	27,050	
Personal Allowance Increase	851,600	341,151	
Coverage for Durable Medical Equipment and Supplies	677,883	271,560	
Coverage of Qualified Medicare Beneficiary	258,189	103,430	
Part D Phase-In	199,259	79,823	
ICF/IID Rate Adjustment	1,327,797	531,916	
Acute Services ICF/IID	1,484,568	594,718	
Non-emergency Transportation - Soonerride	583,660	233,814	
Total Program Costs	**$ 58,255,981**	**$ 23,337,346**	**$ 23,337,346**
Administration			
OHCA Administration Costs	$ 136,628	$ 68,314	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	65,177	65,177	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 201,805**	**$ 133,491**	**$ 133,491**
Total Quality of Care Fee Costs	**$ 58,457,786**	**$ 23,470,837**	
TOTAL STATE SHARE OF COSTS			**$ 23,470,837**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2018, For the Three Month Period Ending September 30, 2017

REVENUES	FY 17 Carryover	FY 18 Revenue	Total Revenue
Prior Year Balance	$ 7,673,082	$ -	$ 4,810,612
State Appropriations	(3,000,000)	-	-
Tobacco Tax Collections	-	11,499,252	11,499,252
Interest Income	-	37,870	37,870
Federal Draws	307,256	8,785,284	8,785,284
TOTAL REVENUES	$ 4,980,338	$ 20,322,406	$ 25,133,018

EXPENDITURES		FY 17 Expenditures	FY 18 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 14,256,038	$ 14,256,038
	College Students/ESI Dental		104,592	41,900
Individual Plan				
	SoonerCare Choice		$ 31,029	$ 12,430
	Inpatient Hospital		754,743	302,350
	Outpatient Hospital		1,044,529	418,438
	BH - Inpatient Services-DRG		91,665	36,721
	BH -Psychiatrist		-	-
	Physicians		1,155,289	462,809
	Dentists		10,414	4,172
	Mid Level Practitioner		4,022	1,611
	Other Practitioners		125,791	50,392
	Home Health		1,205	483
	Lab and Radiology		192,769	77,223
	Medical Supplies		89,898	36,013
	Clinic Services		298,533	119,592
	Ambulatory Surgery Center		40,182	16,097
	Prescription Drugs		3,028,247	1,213,116
	Transportation		27,952	11,198
	Premiums Collected		-	(151,000)
Total Individual Plan			$ 6,896,268	$ 2,611,645
	College Students-Service Costs		$ 101,767	$ 40,768
Total OHCA Program Costs			$ 21,358,664	$ 16,950,350
Administrative Costs				
	Salaries	$ 40,359	$ 540,737	$ 581,096
	Operating Costs	25,578	18,345	43,923
	Health Dept-Postponing	-	-	-
	Contract - HP	103,788	204,423	308,211
Total Administrative Costs		$ 169,725	$ 763,505	$ 933,230
Total Expenditures				$ 17,883,581
NET CASH BALANCE		$ 4,810,612		$ 7,249,437

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2018, For the Three Month Period Ending September 30, 2017

REVENUES	FY 18 Revenue	State Share
Tobacco Tax Collections	$ 229,471	$ 229,471
TOTAL REVENUES	**$ 229,471**	**$ 229,471**

EXPENDITURES	FY 18 Total $ YTD	FY 18 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 3,178	$ 891	
Inpatient Hospital	193,570	$ 54,277	
Outpatient Hospital	779,332	$ 218,525	
Inpatient Services-DRG	-	$ -	
Psychiatrist	-	$ -	
TFC-OHCA	-	$ -	
Nursing Facility	7,616	$ 2,136	
Physicians	1,134,650	$ 318,156	
Dentists	2,098	$ 588	
Mid-level Practitioner	246	$ 69	
Other Practitioners	29,789	$ 8,353	
Home Health	825	$ 231	
Lab & Radiology	60,178	$ 16,874	
Medical Supplies	6,272	$ 1,759	
Clinic Services	42,381	$ 11,884	
Ambulatory Surgery Center	1,343	$ 377	
Prescription Drugs	648,842	$ 181,935	
Transportation	28,260	$ 7,924	
Miscellaneous Medical	1,515	$ 425	
Total OHCA Program Costs	**$ 2,940,095**	**$ 824,403**	
OSA DMHSAS Rehab	$ 16,684	$ 4,678	
Total Medicaid Program Costs	**$ 2,956,778**	**$ 829,081**	
TOTAL STATE SHARE OF COSTS			**$ 829,081**

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.

MAC Meeting
November 16, 2017
(September 2017 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment September 2017	Children September 2017	Adults September 2017	Enrollment Change	Total Expenditures September	PMPM September 2017	Forecasted Sep 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**538,419**	**444,119**	**94,300**	**-3,448**	**$146,649,994**		
	Lower Cost	*(Children/Parents; Other)*	494,059	429,952	64,107	-3,633	$104,586,206	$212	$212
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	44,360	14,167	30,193	185	$42,063,788	$948	$1,015
SoonerCare Traditional			**234,075**	**86,910**	**147,165**	**-2,384**	**$197,875,960**		
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	119,391	82,018	37,373	-2,686	$68,569,844	$574	$499
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	114,684	4,892	109,792	302	$129,306,115	$1,127	$1,237
SoonerPlan			**32,075**	**2,624**	**29,451**	**-1,685**	**$252,127**	$8	$10
Insure Oklahoma			**19,263**	**468**	**18,795**	**-549**	**$6,595,718**		
	Employer-Sponsored Insurance		14,076	272	13,804	-527	$4,414,690	$314	$338
	Individual Plan		5,187	196	4,991	-22	$2,181,028	$420	$452
TOTAL			**823,832**	**534,121**	**289,711**	**-8,066**	**$351,373,799**		

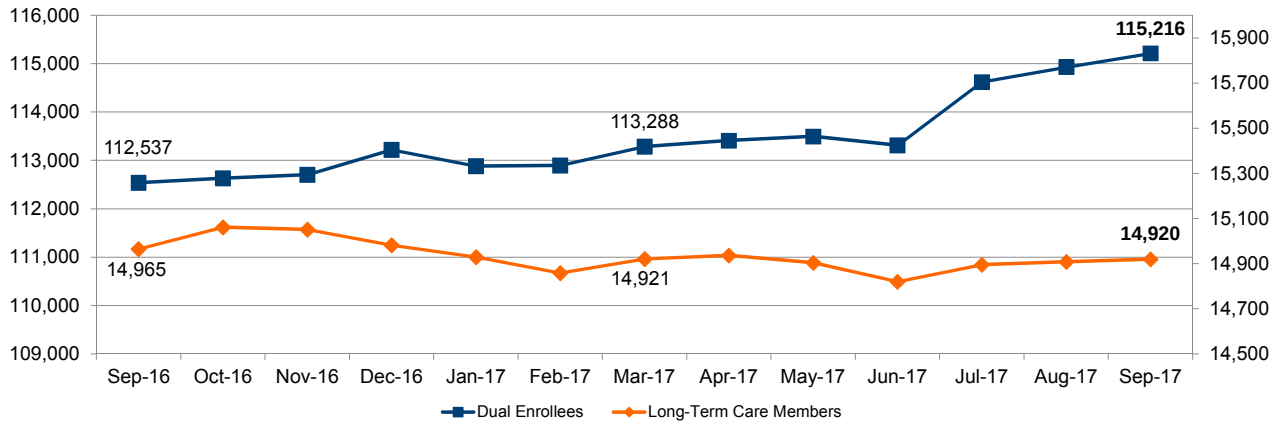
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

Total In-State Providers: 32,083 (+326) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

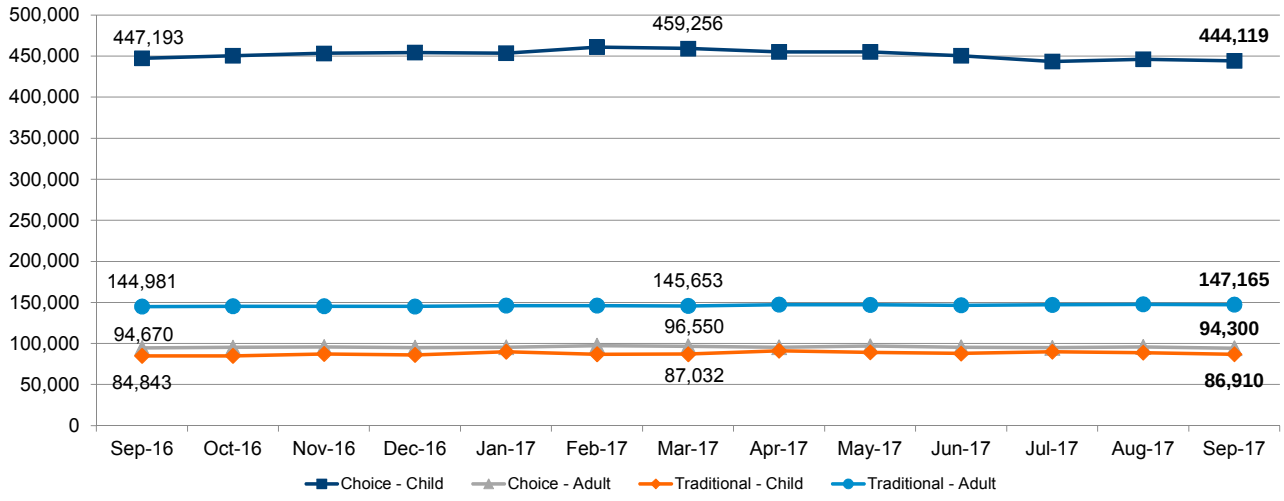
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs*	PCMH
9,589	981	1,350	186	3,455	587	391	6,847	2,686

*PCPs consist of all providers contracted as a Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant.

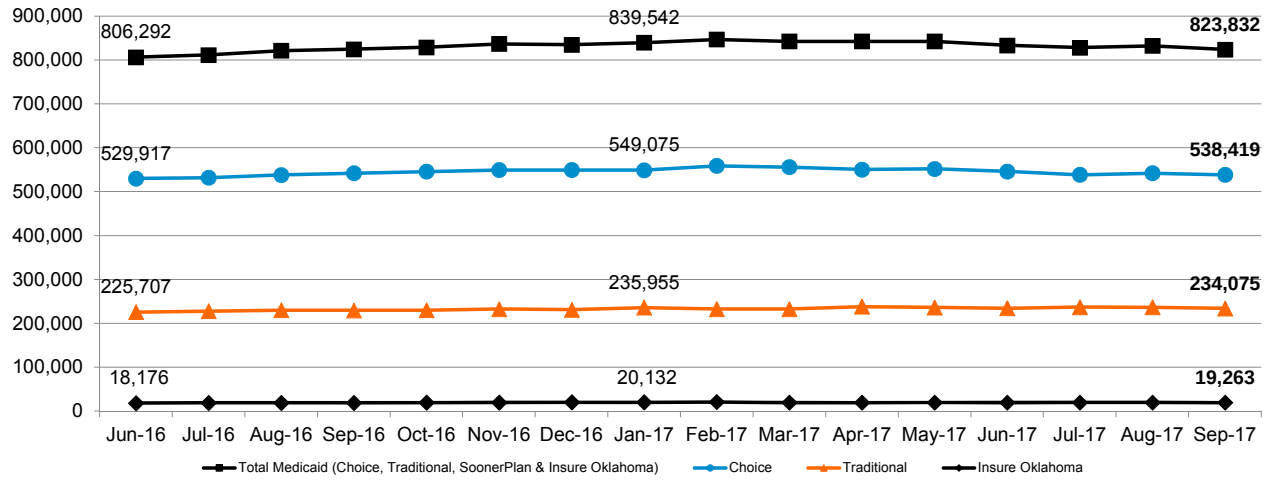
DUAL ENROLLEES & LONG-TERM CARE MEMBERS



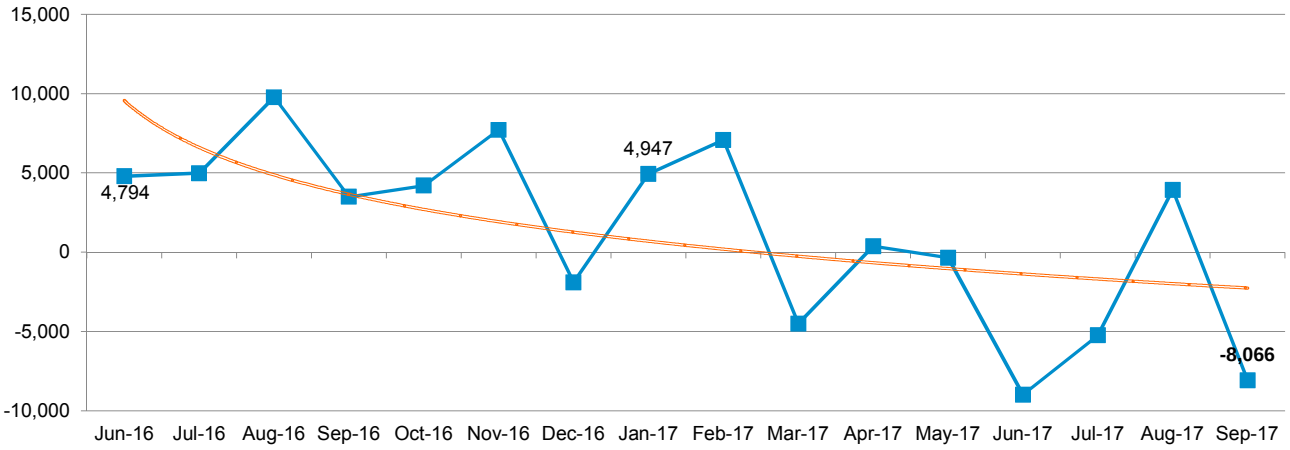
CHILDREN & ADULTS ENROLLMENT



ENROLLMENT BY MONTH



MONTHLY CHANGE IN ENROLLMENT



Oklahoma HealthCare Authority

SoonerCare Tobacco Cessation Strategies

November 16, 2017

Adult Smoking Rates

- Oklahoma adult smoking rate according to Behavioral Risk Factor Surveillance System (BRFSS)
    - 19.6 percent in 2016
        - Down from 22.1 percent in 2015

- Oklahoma Medicaid adult smoking rate based on CAHPS
    - 34.4 percent in 2016
        - Down from 36.7 percent in 2015

Statewide Efforts

- The Oklahoma State Department of Health Oklahoma Health Improvement Plan (OHIP2020)

  -Tobacco use is named as one of the key areas of focus that will have the greatest impact on the health of Oklahomans now and for future generations.

- Tobacco Settlement Endowment Trust (TSET)

  -TSET was established in 2000 following legislation to create a state question, which voters approved, to develop a trust to protect 1998 Master Settlement Agreement funds.

Partnership – Connect4Health

- Under the Connect4Health umbrella, all SoonerCare pregnant women are automatically enrolled in Text4Baby.

- Pregnant women who opt in to the smoking cessation program through Text4Baby are enrolled in Quit4Baby.

- Individuals enrolled in Quit4baby receive educational messages, links to their state quit line and other resources.

Partnership – TSET

- **SoonerQuit for Women Media Campaign**
- **Oklahoma Tobacco Helpline**
- **SoonerQuit Grants**
  - –SoonerQuit Provider Engagement
  - –SoonerQuit Health Promotion

Grants from TSET allow OHCA to draw down federal matching funds for cessation efforts

SoonerQuit for Women

- Oklahoma Tobacco Helpline Branding
  - Media campaign including:
    - TV
    - Radio
    - Billboards
    - Transit (bus wraps, bus benches)
    - Social media
    - Website advertisements

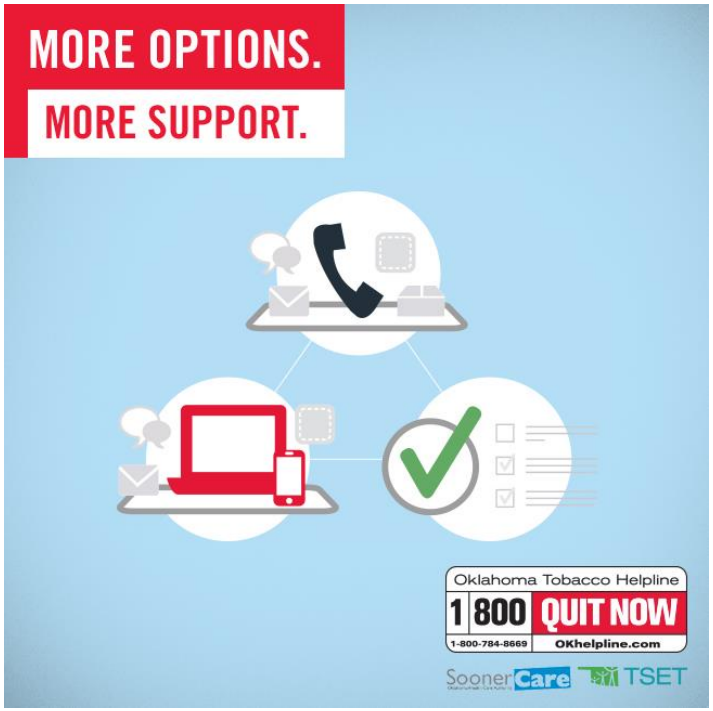
SoonerQuit for Women, *cont.*

Oklahoma HealthCare Authority

Oklahoma Tobacco Helpline

OHCA pays for SoonerCare members to receive the following benefits from the Helpline:

- Calls
- Emails/Web Coach
- Text2Quit
- Materials



SoonerQuit Provider Engagement

- Utilizes practice facilitation to assist providers with implementing evidence-based best practices
- Trains, educates and provides resources to physicians and their staff on SoonerCare cessation benefits and the Oklahoma Tobacco Helpline
- Began in 2010

SoonerQuit Provider Engagement, *cont.*

- Provided facilitation to 82 providers since August 2014
- Reviewed 450 fax referrals to the Oklahoma Tobacco Helpline from OHCA referral partners in SFY 17

SoonerQuit Provider Engagement SFY 16 Evaluation

	Pre-Facilitation	Post-Facilitation
OTH Referrals	66	532

SoonerQuit Provider Engagement SFY 16 Evaluation

	Baseline survey	6 month follow-up	12 month follow-up
Always billed SoonerCare	16%	41%	71%
Sometimes billed SoonerCare	48%	52%	29%
Never billed SoonerCare	36%	7%	0%

SoonerQuit Health Promotion

- Works with community partners, members and providers to promote awareness and increase utilization of cessation services
- Internal policy changes to enhance and increase access to benefits
- SoonerFit.org
- Began in 2015

OHCA Policy Changes

- Nicotine replacement therapy (NRT) and pharmacotherapy
  - No copay
  - No prior authorization
  - No duration limits
  - Does not count towards monthly prescription limit
  - Covers combination therapy

OHCA Policy Changes, *cont.*

- Member cessation counseling benefit
  - Eight (8) sessions per 12 months
  - No copay

- Documentation for cessation counseling sessions
  - No separate progress note
  - No start/stop time

Additional Efforts

- Online health risk assessment
- Developed a database and internal process for Member Services and Population Care Management (PCM) departments to make a referral to the helpline on behalf of the member
- PCM trained in motivational interviewing to encourage behavior change
  - Department works with a large number of pregnant women and households with children

OHCA's Progress

OHCA Tobacco Cessation Services

Members Receiving Services (unique)

Year	Members	Percent Change	Dental	Physician	RX
SFY2016	19,147		2,886	8,654	8,948
SFY2017	21,530	12%	2,569	10,723	9,970

***Services**

Year	Services	Percent Change	Dental	Physician	RX
SFY2016	37,890		3,302	14,996	20,467
SFY2017	43,535	15%	3,102	18,583	23,070

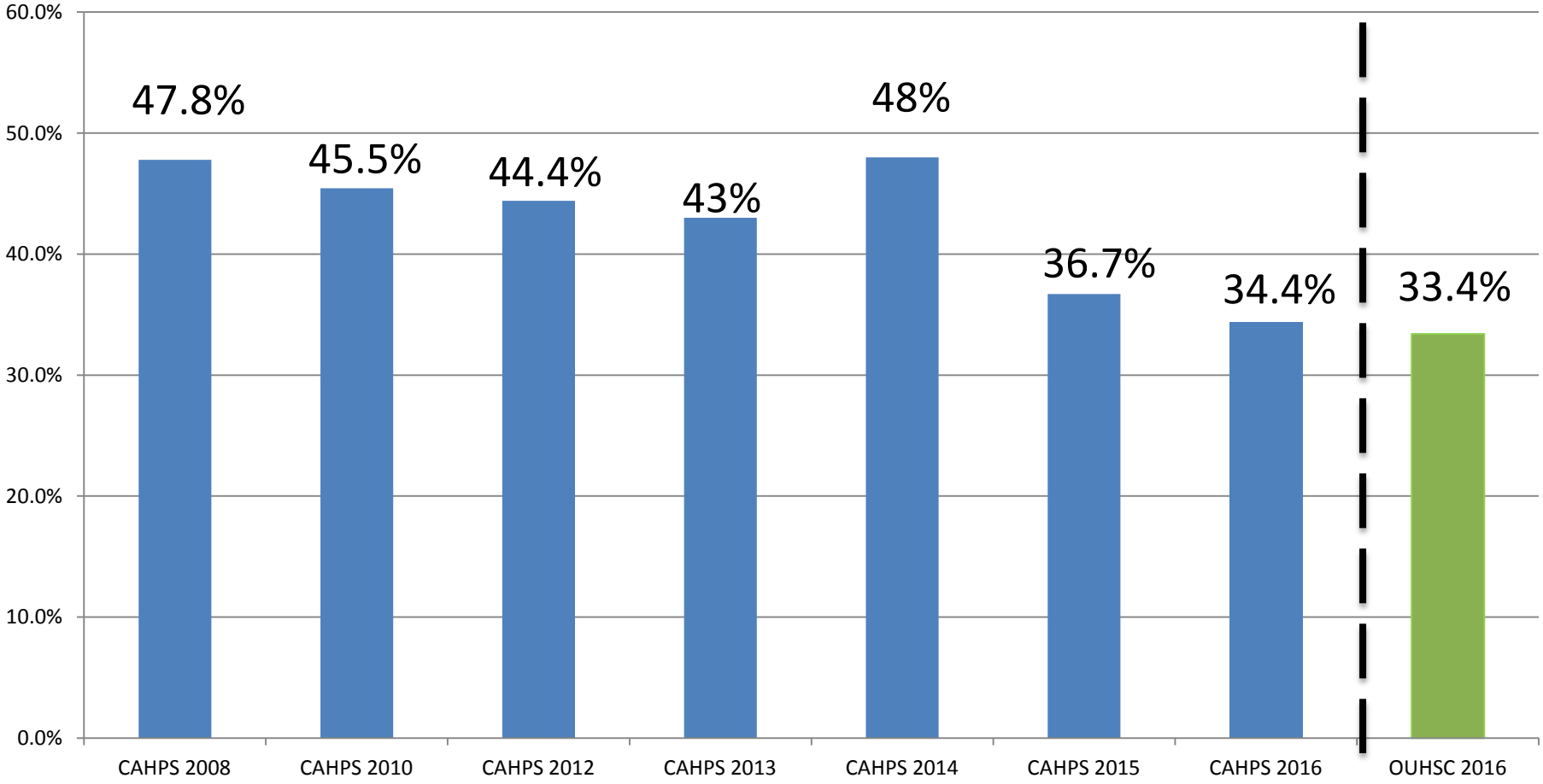
*Members with multiple services in the same calendar month were rolled up as 1 service.

OHCA's Progress, *cont.*

- Registered 4,899 SoonerCare members for Oklahoma Tobacco Helpline services in SFY 17
- Registered 264 pregnant SoonerCare members to the Oklahoma Tobacco Helpline in SFY 17

OHCA's Progress, *cont.*

Tobacco rates among SoonerCare members



Questions?

1st Extraordinary Session of the 56th Legislature

Report for Nov. 16, 2017

Oklahoma's special session continues as lawmakers work to find revenue solutions. Over the past few weeks, several proposals have been introduced:

Senate "Plan B" bills

On Oct. 26, the Senate Joint Committee on Appropriations & Budget (JCAB) introduced and passed five bills they said would be heard in the event a revenue bill that included a gross production tax (GPT) increase failed in the House. The bills immediately went to the House JCAB, where they also passed.

- SB 18X – Appropriates $23.3 million from the Constitutional Reserve (Rainy Day) Fund to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
- SB 23X – Removes the sales tax exemption from gasoline, diesel and compressed natural gas.
- **SB 30X – Appropriates $24.94 million from general revenue carryover to OHCA.**
- SB 32X – Appropriates $29.94 million from general revenue carryover to ODMHSAS.
- SB 34X – Appropriates $29 million from general revenue carryover to the Department of Human Services (DHS).

House "Plan B" bills

On Oct. 30, the House heard its own set of "Plan B" bills. HB 1081X was later heard and passed by the Senate.

- HB 1081X – Appropriates $23.3 million from the Constitutional Reserve (Rainy Day) Fund to ODMHSAS. The bill and its emergency passed 92 to 3.
- **HB 1082X – Appropriates $24.94 million from the FY2017 General Revenue Fund to OHCA. The bill and its emergency passed 92 to 3.**
- HB 1083X – Appropriates $24.94 million from the FY2017 General Revenue Fund to ODMHSAS. The bill and its emergency passed 92 to 3.
- HB 1084X – Appropriates $29.0 million from the FY2017 General Revenue Fund to DHS. The bill and its emergency passed 92 to 3.

Negotiations continue

At the time of this report, lawmakers continue to negotiate changes to the GPT rate and introduce other revenue-raising measures, such as expanding tribal gaming, fuel taxes and low-point beer taxes. HB 1054X, a revenue-raising measure that includes taxes on cigarettes, low-point beer and fuel, as well as a gross production tax increase, is expected to be heard by the House and Senate.

November MAC
Proposed Rule Amendment Summaries

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, September 5, 2017, Thursday, October 19, 2017, and Tuesday, November 7, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA).

APA work folders 17-10A and 17-10B were posted on the OHCA public website for a comment period from September 26, 2017 through October 26, 2017. APA work folder 17-12 was posted on the OHCA public website for a comment period from October 3, 2017 through November 2, 2017. APA work folder 17-18 was posted on the OHCA public website for a comment period from October 17, 2017 through November 16, 2017.

17-10A Expedited Appeals Revisions — The proposed revisions will clarify timelines for appeal decisions and add a new section outlining expedited appeals which are required by new regulations in cases when an appellant's life or health could be in jeopardy. The timelines and process for expedited appeals will be outlined in the new section of policy. In addition, language referring to nursing home wage enhancement will be deleted due to changes in state statute that resulted in the policy being obsolete.
Budget Impact: Budget neutral

17-10B Notification Policy Revisions — In order to avoid violation of state and/or federal law, the proposed revisions will move two sections, regarding notification processes, from the "SoonerCare for Pregnant Women and Families with Children" section to the "Eligibility and Countable Income" section of policy, as the notification policy applies to all SoonerCare programs. Federal regulations require the agency to communicate with members through the members' choice of electronic format or regular mail.
Budget Impact: Budget neutral

17-12 Wage Enhancement Policy Revisions — The proposed revisions will remove wage enhancement language and requirements for specified employees in nursing facilities (NF) serving adults and intermediate care facilities for individuals with intellectual disabilities (ICFs/IIDs). The revisions are necessary to comply with changes in state statute which repealed Title 63 section 5022 and 5022.1. The change in state statue became effective July 1, 2017. The federal minimum wage and the change in rate setting methodology increased the wages for employees of NFs serving adults and ICFs/IIDs, resulting in the policy being obsolete.
Budget Impact: Budget neutral

17-18 Therapeutic Leave Days Revisions — The proposed revisions will eliminate therapeutic leave days for children and adults who reside in long-term care facilities with the exception of Intermediate Care Facilities serving Individuals with Intellectual Disabilities. Without the recommended revisions, the OHCA is at risk of exhausting its State appropriated dollars required to maintain the SoonerCare program.
Budget Impact: The OHCA anticipates that the proposed changes would result in approximately $24,541 state share savings for SFY2018, which would enable OHCA to file a balanced budget.

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals

(a) **Member Process Overview.**

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

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

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

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

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

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. ~~The member must appear at this hearing and it is conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).~~ The member must appear at this hearing, either in person or telephonically. Requests for a telephone hearing must be received in writing on OHCA's LD-4(Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the hearing date. Telephonic hearing requests will only be granted by the OHCA's Chief Executive Officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the CEO of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).

~~(7)~~(8) Member appeals are ordinarily decided within ~~90~~ninety (90) days from the date OHCA receives the member's timely request for a fair hearing unless~~ the member waives this requirement. [Title 42 CFR 431.244(f)]~~, in accordance with 42 CFR § 431.244(f):

(A) The Appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.4;

(B) OHCA cannot reach a decision because the Appellant requests a delay or fails to take a required action, as reflected in the record; or

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record.

~~(8)~~(9) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within ~~20~~twenty (20) days of the hearing before the ALJ.

(b) **Provider Process Overview.**

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

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

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

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

(C) A decision will be rendered by the ALJ ordinarily within ~~45~~forty-five (45) days of the close of all evidence in the case.

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

(c) **ALJ jurisdiction.** The ~~Administrative Law Judge~~ALJ has jurisdiction of the following matters:

(1) ~~Member Appeals:~~**Member Appeals.**

(A) Discrimination complaints regarding the SoonerCare program;
(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;
(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;
(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within ~~20~~twenty (20) days of the hearing before the ALJ;
(E) Proposed administrative sanction appeals pursuant to 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within ~~20~~twenty (20) days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;
(F) Appeals which relate to eligibility determinations made by OHCA;
(G) Appeals of insureds participating in Insure Oklahoma which are authorized by OAC 317:45-9-8(a); and

(2) ~~Provider Appeals:~~**Provider Appeals**.
(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;
(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;
(C) Appeals by Long Term Care facilities for ~~nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and~~ administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)~~,~~and ~~(c)~~(d)(8)~~, and (c)(12)~~;
(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O. S. § 85.1;
(E) Drug rebate appeals;
(F) Provider appeals of OHCA audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and
(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives.
(H) Supplemental Hospital Offset Payment Program (SHOPP)

annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.
(I) Nursing Facility Supplemental Payment Program (NFSPP) eligibility determinations, the assessed amount for each component of the Intergovernmental transfer, Upper Payment Limit payments, the Upper Payment Limit Gap, and penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP.

317:2-1-2.4 Expedited appeals [NEW]

(a) An expedited hearing request may be granted within three (3) working days of the request for hearing, if the time otherwise permitted for a hearing as described in OAC 317:2-1-2(a)(8) could jeopardize the Appellant's life or health or ability to attain, maintain, or regain maximum function.

(b) If OHCA determines that the request meets the criteria for an expedited hearing, it shall:

(1) Initiate the hearing process as described in OAC 317:2-1-5; and

(2) All matters relating to the hearing must be heard and disposed of as expeditiously as possible, but no later than three (3) working days after OHCA has received the request for an expedited hearing.

(c) If OHCA determines that the request does not meet the criteria for an expedited hearing, it shall:

(1) Initiate the ordinary hearing process timeframe, in accordance with OAC 317:2-1-2(a)(8); and

(2) Notify the Appellant of the denial orally or through an electronic notice as described in OAC 317:35-5-66. If oral notification is provided, OHCA will follow up with a written notice within three (3) calendar days of the denial.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-62. Notification of eligibility [RENUMBERED TO 317:35-5-65]

~~When eligibility for SoonerCare is established, the appropriate notice is computer generated to the applicant. When the computer file is updated for changes, notices are generated only if there is a change in the eligibility of any household member.~~

317:35-6-62.1. Electronic Notices [RENUMBERED TO 317:35-5-66]

~~(a) The agency allows SoonerCare members the choice to receive SoonerCare notices and information through electronic formats.~~

~~(1) SoonerCare members who elect to receive electronic notices will have this election confirmed by regular mail.~~

~~(2) SoonerCare members will be able to change this election by regular mail, telephone, or through the SoonerCare application.~~

~~(b) The agency will ensure all notices it generates will be posted to the member's individual account within one business day.~~

~~(1) The agency will send an email or other electronic communication alerting SoonerCare members that a notice has been posted to their member account.~~

~~(2) The agency will not include the member's confidential information in the email or electronic communication alert.~~

~~(3) The agency will send a notice by mail within three business days of a failed email or electronic alert that was undeliverable to the member.~~

~~(4) At the member's request, all notices that are posted to the member's account may also be provided through mail.~~

~~(c) Electronic notices that are posted to the member's account which require the member to take certain action, submit additional documentation, or contain eligibility, appeal, or SoonerCare benefits information are considered the same as if the notice was sent by mail to the member.~~

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 7. APPLICATION, ~~AND~~ ELIGIBILITY DETERMINATION AND NOTIFICATION PROCEDURES

317:35-5-65. Notification of eligibility

When eligibility for SoonerCare is established, the appropriate notice is computer generated to the applicant. When the computer file is updated for changes, notices are generated only if there is a change in the eligibility of any household member.

317:35-5-66. Electronic Notices

(a) The agency allows SoonerCare members the choice to receive SoonerCare notices and information through electronic formats.

(1) SoonerCare members who elect to receive electronic notices will have this election confirmed by regular mail.

(2) SoonerCare members will be able to change this election by regular mail, telephone, or through the SoonerCare application.

(b) The agency will ensure all notices it generates will be posted to the member's individual account within one business day.

(1) The agency will send an email or other electronic communication alerting SoonerCare members that a notice has been posted to their member account.

(2) The agency will not include the member's confidential information in the email or electronic communication alert.

(3) The agency will send a notice by mail within three business days of a failed email or electronic alert that was undeliverable to the member.

(4) At the member's request, all notices that are posted to the member's account may also be provided through mail.

(c) Electronic notices that are posted to the member's account which require the member to take certain action, submit additional documentation, or contain eligibility, appeal, or SoonerCare benefits information are considered the same as if the notice was sent by mail to the member.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. ~~LONG TERM~~LONG-TERM CARE FACILITIES

317:30-5-131.1. Wage enhancement [REVOKED]

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

~~(1) **"Employee Benefits"** means the benefits an employer provides to an employee which include:~~

~~(A) FICA taxes,~~

~~(B) Unemployment Compensation Tax,~~

~~(C) Worker's Compensation Insurance,~~

~~(D) Group health and dental insurance,~~

~~(E) Retirement and pensions, and~~

~~(F) Other employee benefits (any other benefit that is provided by a majority of the industry).~~

~~(2) **"Enhanced"** means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statutes.~~

~~(3) **"Enhancement"** means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statute.~~

~~(4) **"Regular employee"** means an employee that is paid an hourly/salaried amount for services rendered, however, the facility is not excluded from paying employee benefits.~~

~~(5) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022, Title 63 that meet the requirements listed in 42 CFR Section 483.75(e)(1)-(8).~~

~~(b) **Enhancement.** Effective May 1, 1997, the OHCA provides a wage and salary enhancement to nursing facilities serving adults and Intermediate Care Facilities for Individuals with Intellectual Disabilities required by Title 63, Section 5022 of Oklahoma Statutes. The purpose of the wage and salary enhancement is to provide an adjustment to the facility payment rate in order for facilities to reduce turnover and be able to attract and retain qualified personnel. The maximum wage enhancement rates that may be reimbursed to the facilities per diem include:~~

~~(1) Three dollars and fifteen cents ($3.15) per patient day for NFs,~~

~~(2) Four dollars and twenty cents ($4.20) per patient day for standard private ICFs/IID, and~~

~~(3) Five dollars and fifteen cents ($5.15) per patient day for specialized private ICFs/IID.~~

~~(c) **Reporting requirements.** Each NF and ICF/IID is required to submit a Nursing and Intermediate Care Facilities Quarterly Wage~~

Enhancement Report (QER) which captures and calculates specified facility expenses. The report must be completed quarterly and returned to OHCA no later than 45 days following the end of each quarter. QERs must be filed for the State Fiscal Year (SFY) which runs from July 1 to June 30. The Oklahoma Health Care Authority reserves the right to recoup all dollars that cannot be accounted for in the absence of a report. The QER is designed to capture and calculate specified facility expenses for quarterly auditing by the OHCA. The report is used to determine whether wage enhancement payments are being distributed among salaries/wages, employee benefits, or both for the employee positions listed in (1) through (8) of this subsection. Furthermore, the OHCA reserves the right to recoup all dollars not spent on salaries, wages, employee benefits, or both for the employee positions. The specified employee positions included on the QER are:

(1) Licensed Practical Nurse (LPN),
(2) Nurse Aide (NA),
(3) Certified Medication Aide (CMA),
(4) Social Service Director (SSD),
(5) Other Social Service Staff (OSSS),
(6) Activities Director (AD),
(7) Other Activities Staff (OAS), and
(8) Therapy Aide Assistant (TAA).

(d) **Timely filing and extension of time.**

(1) **Quarterly reports.** Quarterly reports are required to be filed within 45 days following the end of each quarter. This requirement is rigidly enforced unless approved extensions of time for the filing of the quarterly report is granted by OHCA. Filing extensions not to exceed 15 calendar days may be granted for extraordinary cause only. A failure to present any of the items listed in (A)-(D) of this paragraph will result in a denial of the request for an extension. The extension request will be attached to the filing of the report after the request has been granted. For an extension to be granted, the following must occur.

(A) An extension request must be received at the Oklahoma Health Care Authority on or before the 30th day after the end of the quarter.

(B) The extension must be addressed on a form supplied by the Health Care Authority.

(C) The facility must demonstrate there is an extraordinary reason for the need to have an extension. An extraordinary reason is defined in the plain meaning of the word. Therefore, it does not include reasons such as the employee who normally makes these requests was absent, someone at the facility made a mistake and forgot to send the form, the facility failed to get documents to some

~~third party to evaluate the expenditures. An unusual and unforeseen event must be the reason for the extension request.~~

~~(D) The facility must not have any extension request granted for a period of two years prior to the current request.~~

~~(2) **Failure to file a quarterly report.** If the facility fails to file the quarterly report within the required (or extended) time, the facility is treated as out of compliance and payments made for the quarter in which no report was filed will be subject to a 100% recoupment. The overpayment is recouped in future payments to the facility immediately following the filing deadline for the reporting period. The full overpayment is recovered within a three month period. The Oklahoma Health Care Authority reserves the right to discontinue wage enhancement payments until an acceptable QER (quarterly enhancement report) is received. In addition to the recoupment of payments, the matter of noncompliance is referred to the Legal Division of the OHCA to be considered in connection with the renewal of the facility's contract.~~

~~(3) **Ownership changes and fractional quarter report.** Where the ownership or operation of a facility changes hands during the quarter, or where a new operation is commenced, a fractional quarter report is required, covering each period of time the facility was in operation during the quarter.~~

~~(A) Fractional quarter reports are linked to the legal requirement that all facility reports be properly filed in order that the overall cost of operation of the facility may be determined.~~

~~(B) Upon notice of any change in ownership or management, the OHCA withholds payments from the facility until a fractional quarter report is received and evaluation of payment for the wage enhancement is conducted. In this case the QER is due within 15 days of the ownership or management change.~~

~~(4) **Pay periods and employee benefits reflected in the QER.** Salaries and wages are determined by accruing the payroll to reflect the number of days reported for the month. Unpaid salaries and wages are accrued through the quarter. Any salaries and wages accrued in the previous quarter and paid in the current quarter are excluded. Employee benefits are determined by accruing any benefits paid to coincide with the reporting month. Unpaid employee benefits are accrued through the quarter. Any employee benefits accrued in the previous quarter and paid in the current quarter are excluded. To be included as an allowable wage enhancement expenditure, accrued salaries, wages and benefits must be paid within forty-five (45) days from the end of the reporting quarter.~~

(5) **Report accuracy.** Errors and/or omissions discovered by the provider after the initial filing/approved extension are not considered grounds for re-opening/revisions of previously filed reports. Furthermore, errors and/or omission discovered by the provider after the initial filing/approved extension can not be carried forward and claimed for future quarterly reporting periods.

(6) **False statements or misrepresentations.** Penalties for false statements or misrepresentations made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, *"(a) Whoever...(2) at any time knowingly and willfully makes or cause to be made any false statement of a material fact for use in determining rights to such benefit or payment... shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. _1320 et. seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both."*

(7) **Audits, desk and site reviews.**

(A) Upon receipt of each quarterly report a desk review is performed. During this process, the report is examined to insure it is complete. If any required information is deemed to have been omitted, the report may be returned for completion. Delays that are due to incomplete reports are counted toward the 45 day deadline outlined in (c) of this Section. At that time the mathematical accuracy of all totals and extensions is verified. Census information may be independently verified through other sources. After completion of the desk review, each report is entered into the OHCA's computerized data base. This facilitates the overall evaluation of the industry's costs.

(B) Announced and/or unannounced site reviews are conducted at a time designated by the OHCA. The purpose of site reviews is to verify the information reported on the QER(s) submitted by the facility to the OHCA. Errors and/or omissions discovered by the OHCA upon the completion of a site review is immediately reflected in future payment(s) to the facility. The OHCA makes deficiencies known to the facility within 30 calendar days. A deficiency notice in no way prevents the OHCA

from additionally finding any overpayment and adjusting future payments to reflect these findings.

(8) **Appeals process.**

(A) If the desk or site review indicates that a facility has been improperly paid, the OHCA will notify the facility that the OHCA will rectify the improper payment in future payments to the facility. Improper payments consist of an overpayment to a facility. The facility may appeal the determination to recoup an alleged overpayment and/or the size of the alleged overpayment, within 20 days of receipt of notice of the improper payment from the OHCA. Such appeals will be Level I proceedings heard pursuant to OAC 317:2-1-2(c)(2). The issues on appeals will be limited to whether an improper payment occurred and the size of the alleged improper payment. The methodology for determining base period computations will not be an issue considered by the administrative law judge.

(B) Certain exceptional circumstances, such as material expenses due to the use of contract employees, overtime expenses paid to direct care staff, or changes within classes of staff may have an effect on the wage enhancement payment and expense results. Facilities may demonstrate and present documentation of the affects of such circumstances before the administrative law judge.

(e) **Methodology for the distribution of payments/adjustments.** The OHCA initiates a two-part process for the distribution and/or recoupment of the wage enhancement.

(1) **Distribution of wage enhancement revenue.** All wage enhancement rates are added to the current facility per diem rate. Facilities receive the maximum wage enhancement rate applicable to each facility type.

(2) **Payment/recoupment of adjustment process.** Initially, all overpayments resulting from the Fourth Quarter of SFY-1997 and the First Quarter of SFY-1998 audits will be deducted from the first month's payment of the Third Quarter of SFY-1998 (January-1998). The Fourth and First Quarter of SFY-1997 and SFY 1998 audit results will be averaged to determine the adjustment. All overpayments as a result of the Second Quarter of SFY-1998 audit will be deducted from the first month's payment of the Fourth Quarter of SFY-1998 (April-1998). Audit results will determine whether or not a facility is utilizing wage enhancement payments that are being added to the facility's per diem rate. When audit results for a given quarter after the Second Quarter of SFY-1998 (October, November, and December 1997) reflect an adjustment, recoupments will be deducted from the facility. Any adjustments calculated will not be recouped during the

quarter in which the calculation is made, rather, they will be recouped during the following quarter. The recoupments, as a result of an adjustment, will not exceed the wage enhancement revenue received for the quarter in which the audit is conducted. Recoupments will be included in the facility's monthly payment and will not exceed the three month period of the quarter in which it is being recouped.

(f) **Methodology for determining base year cost.** The information used to calculate Base Year Cost is taken from actual SFY-1995 cost reports submitted, to the OHCA, by the NFs and ICFs/MR that will be receiving a wage enhancement. A Statewide Average Base Cost is calculated for facilities that did not submit a cost report for SFY-1995. Newly constructed facilities that submit a partial year report are assigned the lower of the Statewide Average Base Cost or actual cost. The process for calculating the Base Year Cost, the Statewide Average Base Cost, and the process for newly constructed facilities is determined as follows.

(1) **Methodology used for determining base year cost.** The methodology for determining the Base Year Cost is determined by the steps listed in (A) through (E) of this paragraph.

(A) Regular employee salaries are determined by adding the salaries of LPNs, NAs, CMAs, SSDs, OSSS, ADs, OAS, and TAAs.

(B) Percentage of benefits allowed are determined by dividing total facility benefits by total facility salaries and wages.

(C) Total expenditures are determined by multiplying the sum of regular employee salaries by a factor of one plus the percentage of benefits allowed in (B) of this subparagraph.

(D) Base Year PPD Costs are determined by dividing total expenditures, in (3) of this subparagraph by total facility patient days. This information is used to determine statewide average base year cost.

(E) Inflated Base Year Costs are determined by multiplying Base Year Cost, in (C) of this subparagraph by the appropriate inflation factors. Base Year Expenditures were adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.

(2) **Methodology used for determining Statewide Average Base Cost.** A Statewide Average Base Cost is calculated for all facilities that did not submit a cost report, to the OHCA,

for SFY-1995. The steps listed in (A) through (C) of this paragraph are applied to determine the Base Cost in the absence of actual SFY-1995 cost report information.

(A) Statewide Average Base Year PPD Costs are determined by adding Base Year PPD Cost, calculated in (1)(D) of this subsection, for all facilities that submitted SFY-1995 cost reports, the sum of this calculation is then divided by the number of facilities that submitted cost reports.

(B) Inflated Base Year PPD Costs are determined by multiplying Statewide Base Year PPD Cost by the appropriate inflation factors. Statewide Base Year PPD Cost was adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.

(C) The facilities base cost is determined by multiplying the facilities' current quarter census by the inflated statewide average PPD costs calculated in (B) of this unit.

(g) **Methodology for determining wage enhancement revenue and expenditure results.** The methodology for determining the facilities' wage enhancement revenue and expenditures results are calculated in (1) through (3) of this paragraph.

(1) **Wage enhancement revenue.** Total wage enhancement revenue received by the facility for the current quarter is calculated by multiplying the facilities total paid Medicaid days for the current quarter by the facilities wage enhancement rate. The Oklahoma Health Care Authority adjusts the computations and results when actual paid Medicaid data for the reporting quarter becomes available.

(2) **Wage enhancement expenditures.** Total wage enhancement expenditures are determined in a four step process as described in (A) through (D) of this paragraph.

(A) Total current quarter allowable expenses are calculated. Salaries and wages of specified staff are totaled and added to the applicable percent of customary employee benefits and 100% of the new employee benefits.

(B) Base period expenditures are calculated. An occupancy adjustment factor is applied to the quarterly average base period cost to account for changes in census.

(C) Current quarter wage enhancement expenditures are calculated by subtracting allowable base period expenditures (see (B) of this subparagraph) from total current quarter allowable expenses (see (A) of this subparagraph).

~~(D) Total wage enhancement expenditures are calculated by adding current quarter wage enhancement expenditures (see (C) of this subparagraph) to prior period wage enhancement expenditures carried forward.~~

~~(3) **Wage enhancement revenue and expenditure results.** Wage enhancement revenue and expenditure results are determined by comparing total wage enhancement revenue (see (1) of this paragraph) to total wage enhancement expenditures (see (2)(D) of this paragraph). Revenue exceeding expenses is subject to recoupment. Expenses exceeding revenue are carried forward to the next reporting period as a prior period wage enhancement expenditure carry over.~~

~~(4) Due to rate increases and increases in the federal minimum wage, wage enhancements to nursing facilities and ICFs/MR are no longer paid.~~

317:30-5-131.2. Quality of care fund requirements and report

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

(1) **"Annualize"** means that the calculations, including, for example, total patient days, gross revenue, or contractual allowances and discounts, is divided by the total number of applicable days in the relevant time period.

(2) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(3) **"Major Fraction Thereof"** means an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

~~(4) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.~~

~~(5)~~(4) **"Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities"** means any home, establishment, or institution or any portion thereof, licensed by the Oklahoma State Department of Health (OSDH) as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

~~(6)~~(5) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

~~(7)~~(6) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this ~~State~~state.

~~(8)~~(7) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

~~(9)~~(8) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority (OHCA) to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the ~~State~~state.

~~(10)~~(9) **"Service ~~rate~~"Rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

~~(11) "Specified staff" means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.~~

~~(12)~~(10) **"Staff Hours ~~worked~~Worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.

~~(13)~~(11) **"Staffing ~~ratios~~"Ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

~~(14)~~(12) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, private pay, and insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

~~(15)~~(13) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(b) **Quality of care fund assessments.**

(1) The OHCA was mandated by the Oklahoma Legislature to assess a monthly service fee to each licensed nursing facility in the ~~State~~state. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) Annually, the Nursing Facilities Quality of Care Fee

shall be determined by using the daily patient census and patient gross receipts report received by the OHCA for the most recent available twelve months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

(3) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services regarding waiver of uniformity requirements related to the fee.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The OHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The OHCA notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the OHCA by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of ~~10%~~10 percent (10%) of the amount and interest of ~~1.25%~~1.25 percent (1.25%) per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. ~~(Central Standard Time)~~, Central Standard Time (CST), of the following business day (Monday-Friday).

(C) The monthly assessment, including applicable penalties and interest, must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for OHCA ~~Cost Reporting~~cost reporting purposes.

(E) The Quality of Care fund, which contains assessments collected including penalties and interest as described in this subsection and any interest attributable to

investment of any money in the fund, must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) All nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

(A) Registered Nurse
(B) Licensed Practical Nurse
(C) Nurse Aide
(D) Certified Medication Aide
(E) Qualified Intellectual Disability Professional (ICFs/IID only)
(F) Physical Therapist
(G) Occupational Therapist
(H) Respiratory Therapist
(I) Speech Therapist
(J) Therapy Aide/Assistant

(3) The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and ~~intermediate care facilities for individuals with intellectual disabilities~~ ICFs/IID must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

~~(d) **Quality of care minimum wage for specified staff.** All nursing facilities and private intermediate care facilities for individuals with intellectual disabilities receiving Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of $6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:~~

~~(1) Registered Nurse~~
~~(2) Licensed Practical Nurse~~
~~(3) Nurse Aide~~

~~(4) Certified Medication Aide~~
~~(5) Other Social Service Staff~~
~~(6) Other Activities Staff~~
~~(7) Combined Social Services/Activities~~
~~(8) Other Dietary Staff~~
~~(9) Housekeeping Supervisor and Staff~~
~~(10) Maintenance Supervisor and Staff~~
~~(11) Laundry Supervisor and Staff~~

~~(c)~~(d) **Quality of care reports.** All nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the OHCA, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the ~~Owner, authorized Corporate Officer, or Administrator~~owner, authorized corporate officer, or administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The ~~Owner~~owner or authorized ~~Corporate Officer~~corporate officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b.

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the ~~Long Term~~Long-term Care Financial Management Unit written notification with adequate, objective, and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the OHCA.

(8) An initial administrative penalty of $150.00 is imposed

upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the OHCA notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For ~~100%~~100 percent (100%) private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for OHCA ~~Cost Reporting~~cost reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of certified nursing assistants, nurses, directors of nursing, and administrators.

(10) Audits may be performed to determine compliance pursuant to subsections (b), ~~(c), and (d)~~and (c) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the OSDH for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The OSHD informs the OHCA of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for OHCA Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of $6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of $25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for OHCA ~~Cost Reporting~~cost reporting purposes.

(13) Under OAC 317:2-1-2, ~~Long Term Care~~long-term care facility providers may appeal the administrative penalty

described in (b)(5)(B) and (e)(8) and (e)(12) of this section.
(14) Facilities that have been authorized by the OSDH to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The ~~Owner, authorized Corporate Officer, or Administrator~~owner, authorized corporate officer, or administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for ~~Flexible Staff Scheduling~~flexible staff scheduling.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-126. Therapeutic leave and Hospital leave

Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made.

~~(1) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven (7) days of therapeutic leave per calendar year for each recipient to reserve the bed.~~

~~(2)~~(1) No payment shall be made to a ~~nursing~~ long-term care facility for ~~hospital leave.~~ therapeutic leave with the exception of an Intermediate Care Facility serving Individuals with Intellectual Disabilities (ICF/IID). In addition, no payment shall be made to a long-term care facility for hospital leave.

~~(3)~~(2) ~~The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)~~ICF/IID may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each ~~recipient~~member to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. ~~Recipients~~Members approved for ICF/IID on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year. No payment shall be made for hospital leave.

~~(4)~~(3) Midnight is the time used to determine whether a patient is present or absent from the facility. The day of discharge for therapeutic leave is counted as the first day of leave, but the day of return from such leave is not counted.

~~(5)~~(4) Therapeutic leave balances are recorded on the Medicaid Management Information System ~~(MMIS)~~. When a patient moves to another facility, it is the responsibility of the transferring facility to forward the patient's leave records to the receiving facility.