OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
March 11, 2010 at 1:00 P.M.
Oklahoma Health Care Authority
4545 N. Lincoln Blvd, Suite 124
Oklahoma City, OK

A G E N D A

Items to be presented by Lyle Roggow, Chairman

1. Call To Order/Determination of Quorum
2. Action Item – Approval of February 11, 2010 OHCA Board Minutes

Item to be presented by Mike Fogarty, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer

    b) Medicaid Director's Update – Lynn Mitchell, M.D.

    c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer

Item to be presented by Chairman Roggow

4. Discussion Item – Reports to the Board by Board Committees

    a) Audit/Finance Committee – Member Miller

    b) Legislative Committee – Member Langenkamp

    c) Rules Committee – Member Langenkamp

    d) Personnel Committee – Member McVay

Item to be presented by Howard Pallotta, General Counsel

5. Announcement of Conflicts of Interest Panel Recommendations for all action items regarding this board meeting

Items to be presented by Mike Fogarty, Chief Executive Officer

6. Discussion Item and Action Item

    a) Discussion Item -Status of Oklahoma Health Care Authority Budget after action by Oklahoma legislature on State Fiscal Year 2010 Budget

    b) Action Item – Amendments to Previous Oklahoma Health Care Authority Board Actions

        1. Rescission of Vote contained under Item 5, subsection 7(a&b) voted upon on February 11, 2010 to reduce Budget Work Program by $5,203,346.00

Items to be presented by Cindy Roberts, Chairperson of State Plan Amendment Rate Committee (SPARC)

7. Action Items – Agency Recommendations for Rate Changes or Modifications to Rate Methods

   a) Consideration and Vote to Reduce Provider Payments for the following contracted services:

      (1)Physician; (2)Hospitals-Inpatient; (3)Outpatient Services; (4)Psychiatric Residential Treatment Facility; (5)Children's Long Term Care Sub-Acute Hospital; (6)Freestanding Rehabilitation Hospital; (7)SoonerChoice Management-Care Coordination; (8)Incentive Payment; (9)Other Provider-Other Practitioner (*i.e.podiatrist, chiropractor);*(10)Home Health Care;(11)Lab and Radiology; (12) Ambulatory Clinic; (13)All Nursing Facility; (14)All Intermediate Care Facility for the Mentally Retarded; (15)Dental; (16)Behavioral Health Rehabilitation; (17)Durable Medical Equipment(DME); and (18)Pharmacy Dispensing Fee, and (19)Injectable Drugs

   b) Consideration and Vote to reduce capped rental durable medical equipment by 10% of the rate published January 1, 2010

   c) Consideration and Vote to alter method for calculation of the State Maximum Allowable Cost (SMAC) for multiple source pharmacy products.

   d) Consideration and Vote to amend the reimbursement methodology for Inpatient Psychiatric Residential Treatment Service to implement a tiered reimbursement system.

Items to be presented by Cindy Roberts, Deputy Chief Executive Officer

8. Action Item – Consideration and Vote of agency recommended rulemaking pursuant to Article I of the Administrative Procedures Act.

   a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of ***all Emergency Rules*** in accordance with 75 Okla. Stat. § 253.

   b) Consideration and Vote Upon promulgation of ***Emergency Rules*** as follows:

   8.b-1 AMENDING agency rules at OAC 317:30-5-740, 30-5-740.1, 30-5-741, 30-5-742, 30-5-742.1, 30-5-742.2, 30-5-743.1, 30-5-744 and 30-5-745, and REVOKING agency rules at 30-5-743 to change outpatient behavioral health reimbursement methodology for services provided in therapeutic foster care settings from an all inclusive per diem payment to fee-for-service. The requirement of "unbundling" per diem rates has been an ongoing trend for CMS and this change more closely aligns our reimbursements with CMS preferences and requirements.
   (Reference APA WF # 10-02)

c) Consideration and Vote Upon ***Permanent Rules*** as follows:

The following rule HAS previously been approved by the Board and has Gubernatorial approval under Emergency Rulemaking. This rule has been REVISED for Permanent Rulemaking.

8.c-1 AMENDING agency rules at OAC 317:35-5-25, 35-6-60, and 35-6-61 regarding coverage for deemed newborns to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. Additionally, rules are being amended to extend the time limited benefit period for Afghans with special immigrant status from six to eight months. Eligibility for these groups will no longer be retroactive to the first day of the month of application but rather, the date of application or later. The only additional change is to section 35-6-60 regarding retroactive eligibility. **(Reference APA WF # 09-55)**

The following rules HAVE previously been approved by the Board and have Gubernatorial approval under Emergency Rulemaking.

8.c-2 AMENDING agency rules at OAC 317:35-17-12, 35-17-17, 35-17-18, and 35-17-21.1, and REVOKING agency rules at 35-17-20 to remove references to the Long Term Care Authority as the Administrative Agent for the ADvantage Program as the Oklahoma Department of Human Services/Aging Services Division has assumed responsibility of the administration of the ADvantage Program. **(Reference APA WF # 09-02 B)**

8.c-3 AMENDING agency rules at OAC 317:35-5-42 to disregard income from temporary census employment. **(Reference APA WF # 09-22)**

8.c-4 AMENDING agency rules at OAC 317:30-3-59, 30-3-60, 30-5-2, 30-5-9 and 30-5-42.17 to be consistent with reimbursement practices and make coverage rules more consistent throughout policy. Revisions include allowing separate payment for the insertion and/or implantation of contraceptive devices during a physician office visit, the removal of physician supervision of hemodialysis or peritoneal dialysis as a general coverage exclusion for both adults and children, the clarification of intent in regards to general coverage and general coverage exclusions for both adults and children, the removal of follow-up consultations, the removal of tympanometry as a general coverage exclusion for children, the clarification of covered critical care guidelines, and general policy cleanup as it relates to these sections. **(Reference APA WF # 09-28)**

8.c-5 AMENDING agency rules at OAC 317:30-5-65, and ADDING agency rules at 30-5-211.17 to clarify the intent of wheelchair coverage for members residing in a long term care facility or ICF/MR and the elimination of the OHCA Certificate of Medical Necessity (CMN) as a document requirement for requesting prior authorization or determining medical necessity for wheelchairs. **(Reference APA WF # 09-32)**

8.c-6 AMENDING agency rules at OAC 317:30-5-20 and 30-5-100 to clarify that reimbursement is only made for medically necessary laboratory services. Additional revisions include removing language which calls for OHCA to edit laboratory claims at the specialty/subspecialty level.
(Reference APA WF # 09-52)

8.c-7 AMENDING agency rules at OAC 317:45-11-20 and 45-11-27 to clarify the intent of offering coverage under the Insure Oklahoma Individual Plan (IP) program. Applicants applying for coverage under the IP program should be uninsured individuals without access to Employer Sponsored Insurance (ESI) or other private health insurance. Rules clarify IP eligibility requirements and closure criteria.
(Reference APA WF # 09-53)

8.c-8 AMENDING agency rules at OAC 317: 35-1-2, 35-5-6, 35-5-6.1, 35-6-15, 35-6-38, 35-6-62, 35-6-63, 35-6-64, 35-6-64.1, 35-7-15, 35-7-60.1, 35-7-63, 35-7-64, 35-7-65, 35-22-9, and 35-22-11 to support the use of the web based online application and eligibility determination system. The process will be phased in over a period of time, beginning with families with children, pregnant women, and individuals requesting only family planning services. Eligibility for these groups will no longer be retroactive to the first day of the month of application but rather, the date of application or later.
(Reference APA WF # 09-56)

8.c-9 AMENDING agency rules at OAC 317:30-5-566 and 30-5-567 to allow reimbursement for services not covered as Medicare Ambulatory Surgical Center (ASC) procedures but otherwise covered under the SoonerCare program. This revision will give OHCA additional flexibility in determining services, which are appropriate for the populations we serve.
(Reference APA WF # 09-59)

8.c-10 AMENDING agency rules at OAC 317:30-5-24 and 30-5-42.1 to clarify the intent of reimbursement for implantable devices inserted during the course of a surgical procedure. Separate payment will be made for implantable devices, but only when the implantable device is not included in the rate for the procedure to insert the device. Additional revisions include removing all-inclusive reimbursement language for outpatient radiological services and additional clarification in regards to adult therapies performed in an outpatient hospital based setting.
(Reference APA WF # 09-60)

8.c-11 AMENDING agency rules at OAC 317:30-5-96.3 to clarify reimbursement for acute inpatient psychiatric services provided in free-standing psychiatric hospitals. The modification more clearly defines reimbursement for ancillary and professional services outside of the per diem rate paid to the facilities.
(Reference APA WF # 09-61)

8.c-12 AMENDING agency rules at OAC 317:30-5-764, 30-5-950, 35-15-13.2, and 35-17-22 to add Case Management and Case Management for Transitioning to the list of services that must be documented utilizing the Interactive Voice Response Authentication (IVRA) system in the ADvantage waiver, and to remove references to the

Long Term Care Authority as the Administrative Agent of the ADvantage Program. Additional revisions include adding Assisted Living services as a compensable service under the ADvantage Waiver program, and clarifying Personal Care rules regarding who could be paid to serve as a Personal Care Assistant (PCA) to SoonerCare members approved for State Plan Personal Care services.
(Reference APA WF # 09-65 A & B)

8.c-13 AMENDING agency rules at OAC 317:30-5-14 to allow a separate payment to be made to providers for the administration of pandemic virus vaccine to both adults and children. This change was brought about by the CMS mandate that State Medicaid agencies reimburse providers for the administration of the 2009 H1N1 flu vaccine. Additional revisions include allowing for a separate payment for the administration of the Human Papillomavirus (HPV) vaccine to the population of members who have been approved for its use by the Advisory Committee on Immunization Practices (ACIP). This revision is to clarify policy to more closely mirror current OHCA practice.
(Reference APA WF # 09-70)

8.c-14 AMENDING agency rules at OAC 317:30-3-5 to increase co-payments for certain medical services provided through SoonerCare. Under Section 1902(a)(14) of the Social Security Act, States are permitted to require certain members to share some of the cost of their health care by imposing upon them such payments as enrollment fees, premiums, deductibles, co-insurance, co-payments, or similar cost sharing charges.
(Reference APA WF # 09-73)

8.c-15 AMENDING agency rules at OAC 317:30-3-57 and 30-5-72 to change the script limit for SoonerCare members from three brand drugs and three generic to two brand drugs and four generic.
(Reference APA WF # 09-74)

8.c-16 AMENDING agency rules at OAC 317:30-5-211.10, 30-5-211.12, 30-5-211.15, 30-5-218, and 30-5-547 to reduce and/or eliminate certain durable medical equipment benefits to adults in order to comply with the budget reductions mandated by the Oklahoma Legislature through the end of State Fiscal Year 2010.
(Reference APA WF # 09-76)

The following rules HAVE previously been approved by the Board and are pending Gubernatorial approval under Emergency Rulemaking.

8.c-17 REVOKING agency rules at OAC 317:30-5-585, 30-5-586 and 30-5-596.2 and AMENDING agency rules at 30-5-595, 30-5-596, 30-5-596.1, 30-5-972 and 30-5-992 to modify targeted case management (TCM) rules to combine adult & children outpatient behavioral health TCM rules into one streamlined set. Revisions also include broadening TCM to all Bachelor of Arts/Bachelor of Science degrees to increase access across the state. Revisions were also made to provide more consistency with Department of Mental Health and Substance Abuse Services (DMHSAS) policy.
(Reference APA WF # 09-64)

8.c-18 AMENDING agency rules at OAC 317:30-5-95.33 to add Licensed Alcohol and Drug Counselors (LADCs) as Licensed Behavioral Health Professionals (LBHPs) under children's inpatient psychiatric treatment rules. This addition would expand the type of licensure their staff can hold in order to provide the services required, as well as allow greater access to care for SoonerCare children that receive inpatient psychiatric treatment services.
(Reference APA WF # 09-68)

8.c-19 AMENDING agency rules at OAC 317:30-3-62 and ADDING agency rules at 30-3-63 to establish policy for hospital acquired conditions. Rules will set policy to no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. The selected conditions that OHCA will recognize are those conditions identified as nonpayable by Medicare.
(Reference APA WF # 09-77)

The following rules HAVE NOT previously been reviewed by the Board.

8.c-20 AMENDING agency rules at OAC 317:35-1-2, 35-5-2, 35-5-7, 35-5-43, 35-5-44, 35-10-26, 35-17-3, and 35-21-11 to clarify rules used by employees of the Oklahoma Department of Human Services and the Oklahoma Health Care Authority when determining an individual's eligibility for Medicaid.
(Reference APA WF # 09-20)

8.c-21 AMENDING agency rules at OAC 317:30-3-40, 30-5-482, 40-5-3, 40-5-8, 40-5-11, 40-5-64, 40-5-101, 40-5-102, 40-5-104, 40-5-110, 40-5-111, 40-5-113, 40-5-150, 40-5-152, 40-5-153, 40-7-12, and 40-7-21 to clarify eligibility requirement for Home and Community Based Services providers, guidelines for Agency Companion Services and Habilitation Training Services, responsibilities of Adult Day Services and Daily Living Supports providers, the provision of nutritional services, requirements for architectural modifications and member eligibility for residence in a group home.
(Reference APA WF # 09-72 A & B)

Items to be presented by Nancy Nesser, PharmD. JD, Pharmacy Director

9. Action Item - Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Oklahoma Statutes § 5030.3.

   a) Consideration and vote to add Atypical Antipsychotic medication to the product based prior authorization program under OAC 317:30-5-77.2(e)

   b) Consideration and vote to add ribavirin solution and dosepacks to the utilization and scope prior authorization under OAC 317:30-5-77.2(e)

Item to be presented by Chairman Roggow

10. Discussion Item - Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Okla. Stat. § 307(B)(1),(4)&(7)

    Status of pending suits and claims

1.Moss v. Wittmer	CJ-08-506 (Creek County)
2.Wright v. OHCA	CJ-09-3924 (Oklahoma County)
3.Boone v. OHCA	CJ-09-10416 (Oklahoma County)

11. New Business

12. Adjournment

NEXT BOARD MEETING
April 08, 2010
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
February 11, 2010
Held at Oklahoma Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on February 10, 2010.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Roggow called the meeting to order at 1:04PM.

BOARD MEMBERS PRESENT: Vice Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

OTHERS PRESENT:

Teresa Schoonmaker, Mike's Medical
Michelle Hoffman, LTCA
Glenda Armstrong, LTCA
Susan Simpson, The Oklahoman
Wes Clingman, OSMA
Nancy Kachel, PPAEO
Sandra Harris, OKDHS
Mary Brinkley, OKAHSA
Lanette Long, St. Anthony
Becky Moore, OAHCP

OTHERS PRESENT:

Mike Garthright, Mike's Medical
Kristin Huber, LTCA
Dennis Teal, Cimarron Medical
Samanatha Galloway, OKDHS
Tracy Jones, Chickasaw Nation
Pam Forducy, Integris Health
Julie Bisbee, The Oklahoman
Rick Snyder, OHA
Ken King, MD, OSMA
Charles Brodt, HP/EDS

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD JANUARY 14, 2010

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION: Vice Chairman Armstrong moved for approval of the January 14, 2010 board minutes as presented. Member McFall seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member Bryant, Member Miller, Member McFall, and Chairman Roggow

ABSTAIN: Member Langenkamp
Member McVay

ITEM 3.a) FINANCIAL UPDATE
Carrie Evans,

Ms. Evans reported that revenues for OHCA through December, accounting for receivables, were **$1,711,458,497** or **.5% over** budget. The Expenditures for OHCA through December, accounting for encumbrances, were **$1,723,275,589** or **.5% over** budget. The state dollar budget variance through December is **$140,229 positive.**

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

Expenditures:	
Medicaid Program Variance	(10.7)
Administration	3.0
Revenues:	
Taxes and Fees	2.3
Drug Rebate	3.1
Overpayments/Settlements	2.4
Total FY 10 Variance	**$ .1**

Ms. Evans reported that even though we are $10 million in the negative on the program side, our administrative spending and revenues are keeping the agency in the black. As we look at January it appears that we will still be in the black. Ms. Evans stated that for February, the agency could be slightly over or in the black. For detailed information, see Tab 3.a of board packet.

ITEM 3.b) MEDICAID DIRECTOR'S UPDATE
Lynn Mitchell, MD

Dr. Mitchell stated that from September thru November we were growing about 5,000-6,000 members every month. The December numbers for SoonerCare are standing 679,294. Dr. Mitchell reported that the SoonerCare Fast Facts shows approximately 15,000 new enrollees that have not been served in the past 6 months. The Insure Oklahoma numbers totaled 30,314 for the month of February and are consistent with previous months. She said that Care Management Program has an average case load per month of 269 with an average of 75 transplant candidates served every month, 158 children that are receiving private duty nursing, 246 with disabilities being served under the TERRA program every month and have seen a rise in high risk ob cases with the average currently 87 being served in Care Management per month. Medical Authorization on a monthly basis handles 5,000 prior authorizations with 55,007 requests yearly. The member service unit has received 8,632 calls through the patient advice line and taken 9,271 calls from pregnant women. Dr. Mitchell reported that through the SooneCare Ride Program there have been 711,825 trips in 2009 which is about 60,000

trips monthly for healthcare services provided. Dr. Mitchell acknowledged Terri Dalton for receiving the Certificate of Excellence Award for this agency through Healthy Business Programs and other state agencies. For detailed information, see Tab 3.b of board packet.

ITEM 3.c) LEGISLATIVE UPDATE
Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez noted that as of noon, Wednesday, February 3, 2010 the Oklahoma Legislature is tracking a total of 4,127 legislative bills for this session. OHCA has 148 carry-over bills. The next deadline is Thursday, February 18th for reporting Senate Bills and Joint Resolutions from Senate committees. Mr. Gomez also noted the Senate and House deadlines. He presented a handout for board members detailing the 2010 OHCA Board tracking reports. For details, see Tab 3.c of board packet.

ITEM 4 – ANNOUNCEMENT OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING
Howard Pallotta, General Counsel

Mr. Pallotta stated that the Conflicts of Interest Panel met with regard to action Items 5, 7, & 8 and found no conflicts.

ITEM 5– CONSIDERATION AND VOTE TO REVISE STATE FISCAL YEAR 2010 OHCA BUDGET WORK PROGRAM TO ACHIEVE A BALANCED BUDGET
Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez stated that he believes that this will be the last round of recommended cuts for state fiscal year 2010. These cuts are to account for the general revenue reduction for the months of February through June totaling $12.1 million in state dollars. This does impact our state/federal matching dollars and will remove more than $30 million dollars in federal money from the SoonerCare program. Mr. Gomez said that we were notified of this reduction by the Office of State Finance and directed to file a revised budget work program by February 19, 2010. Mr. Gomez said that Item 5 if for the board to consider reduction in program expenditures and to revise the SFY10 OHCA Budget Work Program to achieve a balanced budget. Mr. Gomez presented in detail the following reductions for consideration: 1)Administrative Reductions ($1,400,000); 2)Dental Program Reductions ($656,077); 3)Medical Program Reductions($108,662); 4)Increased Third Party Liability and Claim Review Collections($4,485,124); 5)Crossover Co-insurance and Deductible Reductions($349.462);6)Durable Medical Equipment rate Reductions($11,000)and 7)Provider Payment Reductions($5,094,684). For detailed information see Board Agenda Attachment 5.

Chairman Roggow noted this was an order that came down to the Authority from Office of State Finance. The impact that it has on all providers across the state of Oklahoma is huge. OHCA Board is the policy making board and only implement and review policy, and when this happens we have to respond and react. Chairman Roggow stated that this would be an open process and he would allow individuals to speak and address the board at this time. He recognized Dr. Duwayne Koehler, President of the Oklahoma Osteopathic Association. Dr. Koehler thanked OHCA for matching Medicare reimbursement rates. He stated that with a 6.75% loss providers can't stay in business for any length of time.

Providers in the state of Oklahoma are aware that times are lean and most physician practices have not received any increase in Medicare since 2001 though costs have kept going up on a regular basis. Dr. Koehler spoke with regards to the increased health risks involved by eliminating newborn circumcision. Uncircumcised infants are at risk of bladder and kidney infection. Uncircumcised adults are at risk of spreading sexual transmitted diseases. Dr. Koehler asked the board to reconsider cutting Item 3.a.

Chairman Roggow stated that the board continues to look at long term solutions to resolve some of the issues involved.

Chairman Roggow recognized Dr. Kent King of the Oklahoma State Medical Association. Dr. King stated that he is proud to be from a state that has a balanced budget and is fiscally trying to be responsible. He stated that OSMA has been fortunate to work with Dr. Mitchell and Mr. Fogarty regarding the budget reductions. On March 1, there will also be a nationwide cut for physicians related to Medicare that could potentially close the doors of many physicians. Dr. King noted that the state of Oklahoma is 12 years behind on Torte Reform and is surrounded by 6 states that do have Torte Reform in place. He stated that providers/physicians are reimbursed below cost on Medicaid. Medicaid has some of the highest requirements in an attempt to have a high quality programs. Most physicians believe that Medicaid is the highest hassle factor insurance with the lowest reimbursement frequently below cost. Dr. King strongly encouraged OHCA, and the legislature to look at tapping into the stimulus funds to prevent these shortfalls.

Mr. Gomez stated that Representative Doug Cox wrote each of the board members a letter which will be retained for record in the February 2010 board packet. The letter address Dr. Cox's concern for provider rate cuts affecting access. Mr. Gomez noted that copies all available for the public if desired. Mr. Gomez said that in March we will be coming back to the Board and making any cleanup language necessary. Member Langenkamp requested additional information on Items 3 and 6. Mr. Pallotta stated that we do have to meet the balanced budget requirement by law. Mr. Gomez reminded the board that these cuts do not go into effect until April 1. If it is the Board's prerogative to pass the recommendation as it is we can amend it at the March board meeting. Chairman Roggow stated that the impact today potentially carries into state fiscal year 2011.

MOTION: Vice Chairman Armstrong moved for approval of Item 5.1, 5.2, 5.4, 5.5, 5.6, 5.7 and a motion to incorporate the non-acceptance of the elimination of the newborn circumsion program (5.3) and that the amount of $108,662 is included in the final amount approved to give staff time to identify how to come up with $108,662. Member Langenkamp seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

ITEM 6 – REPORTS TO THE BOARD BY BOARD COMMITTEES
Chairman Roggow

6.a)Audit/Finance Committee
Member Miller

Member Miller stated that he met with Ms. Evans and OHCA is financially in the positive. It appears that the month of February may be in the negative. The committee also met with Ms. Roberts and discussed the Quarterly Audit Report.

6.b)Legislative Committee
Member McFall

Member McFall stated last week that he along with Vice Chairman Armstrong, Chairman Roggow, Mr. Gomez, and Dr. Mitchell met with the President Pro-Tempore of the Senate and the Treasurer and have an appointment next Tuesday afternoon to meet with the Speaker of the House. He noted that all conversations this week went well and tried to point out to legislators that board members and staff were there to offer some solutions to the financial problems. Member McFall stated the one thing was conveyed to the Pro-Tempore and Treasurer was that OHCA does not want to cut provider rates but are forced to in order to achieve a balanced budget. Member McFall stated that we can't cut programs because those programs are bringing the federal stimulus money.

6.c)Rules Committee
Member Langenkamp

Member Langenkamp stated that the Rules Committee did meet and briefly discussed the upcoming rules to be presented by Ms. Roberts.

ITEM 7.a)CONSIDERATION AND VOTE TO AUTHORIZE EXPENDITURE OF FUNDS TO AMEND THE MY INNERVIEW CONTRACT TO EXTEND IT UP TO 12 MONTHS
Beth VanHorn, Director of Legal Operations

Ms. VanHorn stated that the Focus on Excellence (FOE) is the Oklahoma Health Care Authority's program to assess and reward the quality-improvement efforts of long term care facilities. The program measures the relative quality of nursing facilities in Oklahoma and provides a payment for nursing homes that report and improve quality measures. OHCA has contracted with My InnerView since July 1, 2007 to develop and operate the program. The contract was set to terminate on June 30, 2010.

Ms. VanHorn noted that because of an independent evaluation of this program and new recommendations from the contractor, OHCA needs additional time to consider and implement program changes before rebidding the contract. The amendment allows for the extension of the contract for up to 12 months, no later than June 30, 2011. The cost of

a one-year extension for FY11 would be with no increase over the FY10 amount

Ms. VanHorn asked the Board for approval to expend funds to extend the contract with My InnerView; Board approval is contingent on approval by the Department of Central Services

MOTION: Member McFall moved for approval of Item 7.a as presented. Member McVay seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

ITEM 7.b)CONSIDERATION AND VOTE TO AUTHORIZE EXPENDITURE OF FUNDS TO AMEND THE HEWLETT PACKARD(HP)/ELECTRONIC DATA SYSTEMS(EDS) CONTRACT TO INCREASE THE AMOUNT FOR A CLAIMS SETTLEMENT

Beth VanHorn, Director of Legal Operations

Ms. VanHorn stated that Hewlett Packard ("HP") formerly Electronic Data Systems, LLC ("EDS") is contracted to develop, operate and maintain OHCA's MMIS (Medicaid Management Information System). The original acquisition was made by competitive bid. The Department of Central Services has approved this amendment to the bid pricing and tasks.

Ms. VanHorn asked for Board approval to expend funds for the HP contract amendment; Board approval is contingent on approval by the Department of Central Services and the Centers for Medicare and Medicaid Services

MOTION: Vice Chairman Armstrong moved for approval of Item 7.b as presented. Member McFall seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

ITEM 8.a)CONSIDERATION AND VOTE UPON A DECLARATION OF A COMPELLING PUBLIC INTEREST FOR THE PROMULGATION OF ALL EMERGENCY RULES IN ACCORDANCE WITH 75 OKLA. STAT. § 253

Cindy Roberts, Deputy Chief Executive Officer

MOTION: Member McFall moved for declaration of a compelling public interest for promulgation of all emergency rules as presented. Member Bryant seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

ITEM 8.b)CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:
Cindy Roberts, Deputy Chief Executive Officer

8.b-1 through 8.b-3 as published in meeting agenda.

MOTION: Member McFall moved for approval of emergency rules 8.b-1 thru 8.b-3 as presented. Member McVay seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

ITEM 8.c-1)CONSIDERATION AND VOTE UPON PERMANENT RULE THAT HAS PREVIOUSLY BEEN APPROVED BY THE BOARD AND HAS GUBERNATORIAL APPOVAL UNDER EMERGENCY RULEMAKING. THIS RULE HAS BE REVISED FOR PERMANENT RULEMAKING
Cindy Roberts, Deputy Chief Executive Officer

8.c-1 as published in meeting agenda.

MOTION: Vice Chairman Armstrong moved for approval of permanent rule 8.c-1 as presented. Member McFall seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

ITEM 8.c-2 thru 8.c-24)CONSIDERATION AND VOTE UPON PERMANENT RULES AS FOLLOWS:
Cindy Roberts, Deputy Chief Executive Officer

8.c-2 through 8.c-24 as published in meeting agenda.

MOTION: Member Langenkamp moved for approval of permanent rules 8.c-2 thru 8.c-24 as presented. Member McVay seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

ITEM 9 - DISCUSSION ITEM – PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLA. STATE. §307(B)(1),(4)&(7)
Howard Pallotta, Director of Legal Services

MOTION: Member McFall moved for an executive session. Member McVay seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

ITEM 10/NEW BUSINESS

None

ITEM 11/ADJOURNMENT

MOTION: Member McFall moved for adjournment. Vice Chairman Armstrong seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

FINANCIAL REPORT

For the Seven Months Ended January 31, 2010
Submitted to the CEO & Board
March 11, 2010

- Revenues for OHCA through January, accounting for receivables, were **$2,114,498,276** or **.5% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,957,853,892** or **.5% over** budget.
- The state dollar budget variance through January is **$1,070,748 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(10.7)
Administration		2.4
Revenues:		
Taxes and Fees		3.2
Drug Rebate		3.5
Overpayments/Settlements		2.7
Total FY 10 Variance	**$**	**1 .1**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2010, for the Seven Months Ended January 31, 2010

REVENUES	FY10 Budget YTD	FY10 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 385,556,424	$ 385,556,424	$ -	0.0%
Federal Funds	1,193,848,080	1,184,422,650	(9,425,430)	(0.8)%
Tobacco Tax Collections	28,907,882	32,680,883	3,773,001	13.1%
Quality of Care Collections	30,102,489	29,561,935	(540,554)	(1.8)%
Prior Year Carryover	23,404,558	23,404,558	-	0.0%
Drug Rebates	83,368,900	93,525,062	10,156,162	12.2%
Medical Refunds	18,102,172	25,625,965	7,523,793	41.6%
Other Revenues	11,086,828	10,936,032	(150,795)	(1.4)%
TOTAL REVENUES	**$ 2,103,162,100**	**$ 2,114,498,276**	**$ 11,336,177**	**0.5%**

EXPENDITURES	FY10 Budget YTD	FY10 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 23,002,656**	**$ 21,745,201**	**$ 1,257,455**	**5.5%**
ADMINISTRATION - CONTRACTS	**$ 63,351,398**	**$ 49,308,920**	**$ 14,042,478**	**22.2%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	$ 16,532,956	$ 15,960,812	$ 572,145	3.5%
Acute Fee for Service Payments:				
Hospital Services	537,461,167	526,375,187	11,085,979	2.1%
Behavioral Health	150,646,779	161,744,100	(11,097,321)	(7.4)%
Physicians	256,625,273	260,948,917	(4,323,644)	(1.7)%
Dentists	88,349,060	95,855,622	(7,506,562)	(8.5)%
Other Practitioners	25,540,010	27,454,537	(1,914,527)	(7.5)%
Home Health Care	10,992,491	11,642,486	(649,995)	(5.9)%
Lab & Radiology	14,183,242	17,345,727	(3,162,485)	(22.3)%
Medical Supplies	33,783,814	31,949,302	1,834,511	5.4%
Ambulatory Clinics	35,616,979	41,037,576	(5,420,597)	(15.2)%
Prescription Drugs	216,313,966	219,920,006	(3,606,041)	(1.7)%
Miscellaneous Medical Payments	17,656,596	16,336,288	1,320,307	7.5%
Other Payments:				
Nursing Facilities	302,643,561	303,728,342	(1,084,780)	(0.4)%
ICF-MR Private	32,765,387	32,805,706	(40,319)	(0.1)%
Medicare Buy-In	68,280,288	68,871,066	(590,779)	(0.9)%
Transportation	15,066,999	15,116,819	(49,819)	(0.3)%
Part D Phase-In Contribution	38,735,714	39,707,278	(971,564)	(2.5)%
Total OHCA Medical Programs	**1,861,194,282**	**1,886,799,771**	**(25,605,489)**	**(1.4)%**
OHCA Non-Title XIX Medical Payments	40,128	-	40,128	0.0%
TOTAL OHCA	**$ 1,947,588,464**	**$ 1,957,853,892**	**$ (10,265,428)**	**(0.5)%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 155,573,636**	**$ 156,644,384**	**$ 1,070,748**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year Ended 2010, for the Seven Months Ended January 31, 2010

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 16,150,952	$ 15,940,778	$ -	$ 190,140	$ -	$ 20,034	$ -
Inpatient Acute Care	438,807,841	358,559,873	283,901	6,147,151	29,134,025	3,253,655	41,429,238
Outpatient Acute Care	139,291,663	130,965,253	24,269	4,147,929	-	4,154,213	
Behavioral Health - Inpatient	78,467,850	76,352,630	-	3,088	-	-	2,112,133
Behavioral Health - Outpatient	4,987,598	4,964,238	-	-	-	-	23,360
Behavioral Health Facility- Rehab	95,005,054	80,162,976	-	104,485	-	74,260	14,663,333
Behavioral Health - Case Management	189,996	189,650	-	-	-	346	
Residential Behavioral Management	15,413,133	-	-	-	-	-	15,413,133
Targeted Case Management	43,860,645	-	-	-	-	-	43,860,645
Therapeutic Foster Care	-	-	-	-	-	-	-
Physicians	286,554,120	215,624,082	33,892	6,448,508	36,978,989	8,311,954	19,156,695
Dentists	95,860,062	91,403,326	-	4,439	4,326,138	126,158	-
Other Practitioners	27,641,188	26,688,929	260,379	186,651	469,327	35,902	-
Home Health Care	11,642,547	11,594,522	-	60	-	47,964	-
Lab & Radiology	18,196,305	16,730,333	-	850,579	-	615,393	-
Medical Supplies	32,274,991	30,089,784	1,690,197	325,688	-	169,322	-
Ambulatory Clinics	47,320,427	40,554,513	-	666,474	-	483,062	5,616,377
Personal Care Services	7,325,260	-	-	-	-	-	7,325,260
Nursing Facilities	303,728,342	196,488,371	82,767,853	-	24,456,084	16,034	-
Transportation	15,116,819	13,616,802	1,463,277	-	28,132	8,609	-
GME/IME/DME	78,491,279	-	-	-	-	-	78,491,279
ICF/MR Private	32,805,706	21,817,562	10,486,301	-	501,842	-	-
ICF/MR Public	44,451,283	-	-	-	-	-	44,451,283
CMS Payments	108,578,344	105,189,171	3,389,173	-	-	-	-
Prescription Drugs	226,595,581	193,445,188	-	6,675,574	24,267,136	2,207,682	-
Miscellaneous Medical Payments	16,336,288	15,477,389	-	-	767,849	91,051	-
Home and Community Based Waiver	92,374,079	-	-	-	-	-	92,374,079
Homeward Bound Waiver	55,698,811	-	-	-	-	-	55,698,811
Money Follows the Person	927,925	-					927,925
In-Home Support Waiver	15,014,389	-	-	-	-	-	15,014,389
ADvantage Waiver	121,214,667	-	-	-	-	-	121,214,667
Family Planning/Family Planning Waiver	4,397,061	-	-	-	-	-	4,397,061
Premium Assistance*	27,250,259	-		27,250,259	-		-
Total Medicaid Expenditures	**$ 2,501,970,464**	**$1,645,855,369**	**$ 100,399,242**	**$ 53,001,026**	**$ 120,929,521**	**$ 19,615,639**	**$ 562,169,667**

* Includes $26,250,258.54 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2010, for the Seven Months Ended January 31, 2010

		FY10 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	184,433,356
Federal Funds		366,543,211
TOTAL REVENUES	**$**	**550,976,567**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	92,374,079
Money Follows the Person		927,925
Homeward Bound Waiver		55,698,811
In-Home Support Waivers		15,014,389
ADvantage Waiver		121,214,667
ICF/MR Public		44,451,283
Personal Care		7,325,260
Residential Behavioral Management		12,022,537
Targeted Case Management		34,154,664
Total Department of Human Services		**383,183,615**
State Employees Physician Payment		
Physician Payments		19,156,695
Total State Employees Physician Payment		**19,156,695**
Education Payments		
Graduate Medical Education		31,150,000
Graduate Medical Education - PMTC		6,536,750
Indirect Medical Education		28,137,940
Direct Medical Education		12,666,589
Total Education Payments		**78,491,279**
Office of Juvenile Affairs		
Targeted Case Management		1,734,747
Residential Behavioral Management - Foster Care		85,184
Residential Behavioral Management		3,305,412
Multi-Systemic Therapy		23,360
Total Office of Juvenile Affairs		**5,148,702**
Department of Mental Health		
Targeted Case Management		46,393
Hospital		2,112,133
Mental Health Clinics		14,663,333
Total Department of Mental Health		**16,821,859**
State Department of Health		
Children's First		1,471,551
Sooner Start		1,600,125
Early Intervention		3,744,769
EPSDT Clinic		1,357,440
Family Planning		67,744
Family Planning Waiver		4,299,637
Maternity Clinic		95,301
Total Department of Health		**12,636,567**
County Health Departments		
EPSDT Clinic		497,806
Family Planning Waiver		29,679
Total County Health Departments		**527,485**
State Department of Education		**125,584**
Public Schools		**2,582,938**
Medicare DRG Limit		**39,492,916**
Native American Tribal Agreements		**2,065,705**
Department of Corrections		**32,842**
JD McCarty		**1,903,479**
Total OSA Medicaid Programs	**$**	**562,169,667**
OSA Non-Medicaid Programs	**$**	**5,474,240**
Account Receivable from OSA	**$**	**16,667,340**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2010, For the Seven Months Ended January 31, 2010

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 29,537,262	$ 29,537,262
Interest Earned	24,673	24,673
TOTAL REVENUES	**$ 29,561,935**	**$ 29,561,935**

EXPENDITURES	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 80,560,323	$ 28,357,234	
Eyeglasses and Dentures	175,830	61,892	
Personal Allowance Increase	2,031,700	715,158	
Coverage for DME and supplies	1,690,197	594,949	
Coverage of QMB's	602,441	212,059	
Part D Phase-In	3,389,173	3,389,173	
ICF/MR Rate Adjustment	8,055,132	2,835,407	
Acute/MR Adjustments	2,431,169	855,771	
NET - Soonerride	1,463,277	515,073	
Total Program Costs	**$ 100,399,242**	**$ 37,536,717**	**$ 37,536,717**
Administration			
OHCA Administration Costs	$ 303,821	$ 151,910	
DHS - 10 Regional Ombudsman	95,935	95,935	
OSDH-NF Inspectors	129,729	129,729	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 529,485**	**$ 377,575**	**$ 377,575**
Total Quality of Care Fee Costs	**$ 100,928,727**	**$ 37,914,292**	
TOTAL STATE SHARE OF COSTS			**$ 37,914,292**

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

Fiscal Year 2010, for the Seven Months Ended January 31, 2010

REVENUES	FY 09 Carryover	FY 10 Revenue	Total Revenue
Prior Year Balance	$ 37,974,903		$ 29,412,736
Tobacco Tax Collections	-	26,878,306	26,878,306
Interest Income	-	884,460	884,460
Federal Draws	-	17,638,697	17,638,697
All Kids Act	(8,000,000)		-
TOTAL REVENUES	**$ 29,974,903**	**$ 45,401,462**	**$ 74,814,198**

EXPENDITURES	FY 09 Expenditures	FY 10 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		**$ 27,250,259**	**$ 27,250,259**
Individual Plan			
SoonerCare Choice		$ 188,235	$ 66,259
Inpatient Hospital		6,142,182	2,162,048
Outpatient Hospital		4,125,448	1,452,158
Behavioral Health - Inpatient Services		3,088	1,087
Behavioral Health Facility - Rehabilitation Se		103,943	36,588
Behavioral Health - Case Management		-	-
Physicians		6,428,728	2,262,912
Dentists		4,439	1,563
Other Practitioners		185,225	65,199
Home Health		60	21
Lab and Radiology		844,839	297,383
Medical Supplies		325,427	114,550
Ambulatory Clinics		665,075	234,106
Prescription Drugs		6,649,193	2,340,516
Premiums Collected			(2,604,867)
Total Individual Plan		**$ 25,665,881**	**$ 6,429,523**
College Students-Service Costs		**$ 84,886**	**$ 29,880**
Total Program Costs		**$ 53,001,026**	**$ 33,709,662**
Administrative Costs			
Salaries	$ 18,023	$ 714,255	$ 714,255
Operating Costs	289,025	416,210	416,210
Contract - Electronic Data	255,119	1,168,762	1,168,762
Total Administrative Costs	**$ 562,167**	**$ 2,299,227**	**$ 2,299,227**
Total Expenditures			**$ 36,008,889**
NET CASH BALANCE	**$ 29,412,736**		**$ 38,805,310**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2010, for the Seven Months Ended January 31, 2010

REVENUES	FY 10 Revenue	State Share
Tobacco Tax Collections	$ 536,533	$ 536,533
TOTAL REVENUES	**$ 536,533**	**$ 536,533**

EXPENDITURES	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 20,034	$ 4,936	
Inpatient Hospital	3,253,655	801,701	
Outpatient Hospital	4,154,213	1,023,598	
Inpatient Free Standing	-	-	
MH Facility Rehab	74,260	18,298	
Case Mangement	346	85	
Nursing Facility	16,034	3,951	
Physicians	8,311,954	2,048,065	
Dentists	126,158	31,085	
Other Practitioners	35,902	8,846	
Home Health	47,964	11,818	
Lab & Radiology	615,394	151,633	
Medical Supplies	169,322	41,721	
Ambulatory Clinics	483,062	119,027	
Prescription Drugs	2,207,682	543,973	
Transportation	8,609	2,121	
Miscellaneous Medical	91,051	22,435	
Total Program Costs	$ 19,615,640	$ 4,833,294	**$ 4,833,294**
TOTAL STATE SHARE OF COSTS			**$ 4,833,294**

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 255: OHCA Medicaid Program Fund
Fiscal Year 2010, For the Seven Months Ended January 31, 2010

REVENUES	FY 10 Total Revenue	FY 10 State Share
Tobacco Tax Collections	$ 32,144,350	$ 32,144,350
TOTAL REVENUES	**$ 32,144,350**	**$ 32,144,350**

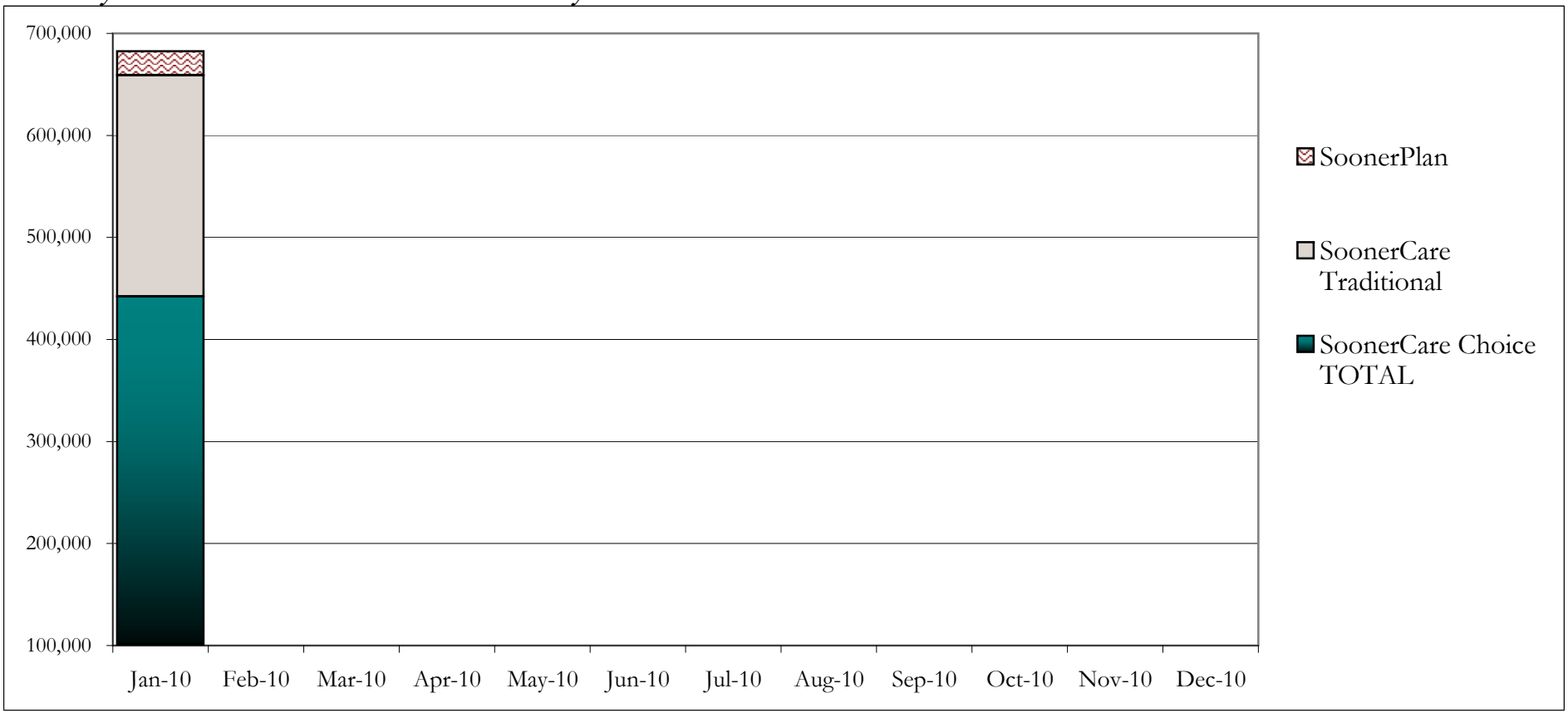
EXPENDITURES Program Costs:	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Adult Dental Services	$ 4,326,138	$ 1,522,801	
Remove Hospital Day Limit	7,055,536	2,483,549	
Hospital Rate Increase - Statewide Median +2%	10,140,058	3,569,300	
Increase Physician Visits from 2 to 4 per Month	309,072	108,793	
Increase Physician Office Visits/OB Visits to 90% of Medicare	17,766,129	6,253,677	
Increase Emergency Room Physician Rates to 90% of Medicare	8,411,346	2,960,794	
Pay 50% of Medicare Crossover - Physician/Ambulance/OP	11,729,617	4,128,825	
Nursing Facility 7% Rate Increase	19,594,766	6,897,358	
Enhanced Drug Benefit for Adults 3 + 3	13,087,886	4,606,936	
Enhanced Drug Benefit for Waiver Adults 3 + 10	11,179,250	3,935,096	
TEFRA Services	6,739,753	2,372,393	
SoonerRide	28,132	9,902	
Replace NSGO Medicare DRG Limit Revenues	10,561,838	3,717,767	
Total Program Costs	**$ 120,929,521**	**$ 42,567,191**	**$ 42,567,191**
TOTAL SHATE SHARE OF COSTS			**$ 42,567,191**

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

SOONERCARE ENROLLMENT CY-2010

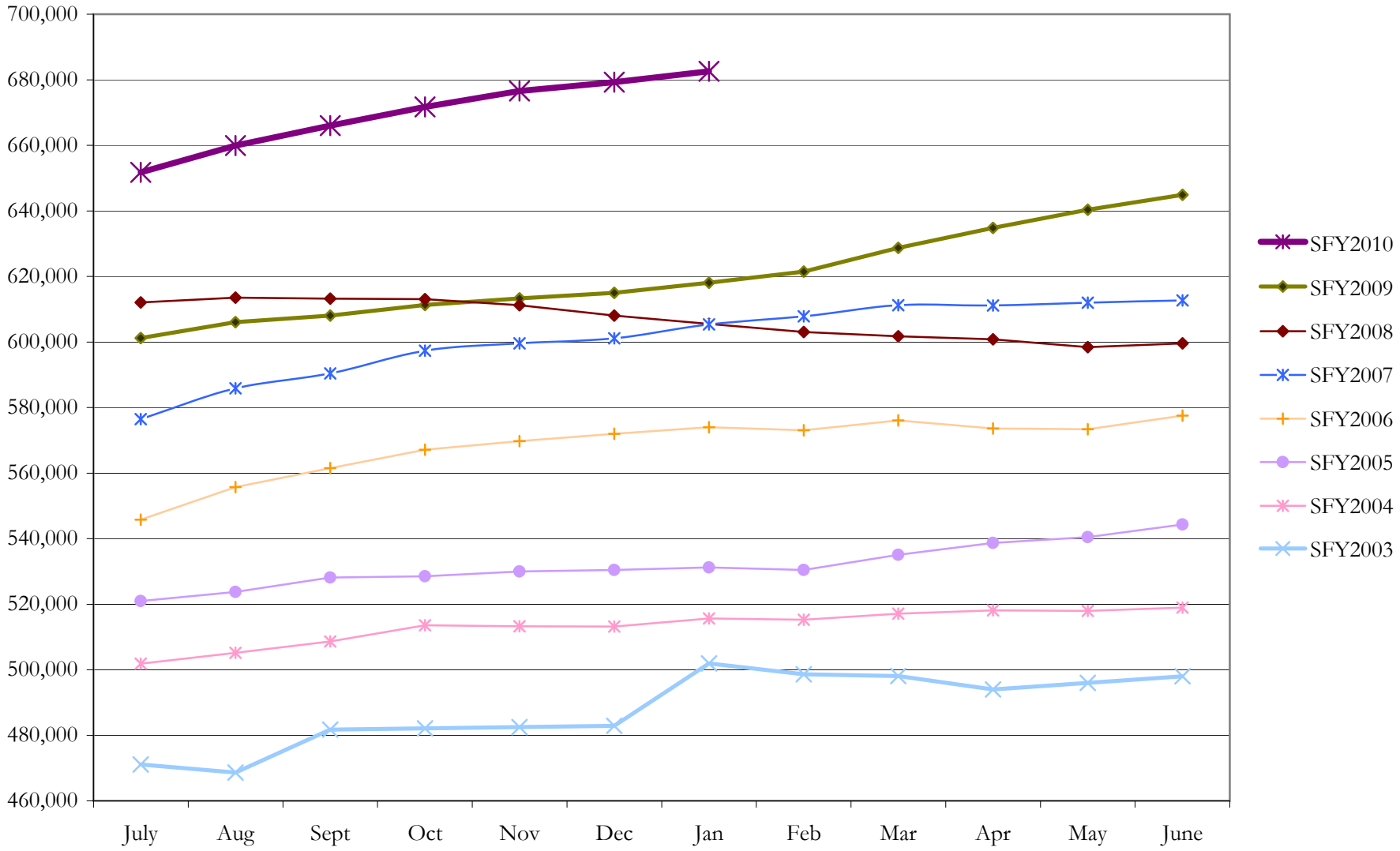
	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice Total	428,704												428,704
IHS/Urban/Tribal Total	13,503												13,503
SoonerCare Choice TOTAL	442,207												442,207
SoonerCare Traditional	216,989												
SoonerPlan	23,420												23,420
TOTAL ENROLLEES	682,616												682,616
Average Monthly Enrollment													682,616

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months

OHCA SoonerCare Enrollment Figures



SoonerCare Programs

January 2010

Choice PCMH	January 2009	January 2010
TOTAL	410,567	442,207
American Indian Enrollees	11,728	13,503
Choice enrollees (enhanced PCMH)	398,839	428,704

Traditional	January 2009	January 2010
Members	190,117	216,989
SoonerCare Programs Total Unduplicated	618,056	682,616

Oklahoma Cares	January 2009	January 2010
Women currently enrolled	2,490	2,307
SoonerCare Traditional	1,866	1,595
SoonerCare Choice	624	712
Women ever-enrolled	18,356	22,260

Insure Oklahoma/ O-EPIC	January 2009	January 2010
IO Total Enrollees	16,584	29,621
IO Total Enrollees **(Male : Female)**	7,272 : 9,312	12,897 : 16,724
ESI Enrollees	11,078	18,521
IP Enrollees	5,506	11,100

TEFRA	January 2009	January 2010
Children enrolled	246	325
Male Enrollees	148	194
Female Enrollees	98	131
Ever-enrolled	323	423

SoonerPlan	January 2009	January 2010
Enrolled	17,013	23,420
Male enrollees	486	703
Female enrollees	16,527	22,717
Ever-enrolled	63,329	78,371

PROGRAM	AUGUST 2009	SEPTEMBER 2009	OCTOBER 2009	NOVEMBER 2009	DECEMBER 2009	JANUARY 2010
Choice PCMH	419,374	422,926	423,288	432,068	438,276	442,207
Traditional	219,633	221,392	225,914	221,734	217,945	216,989
Oklahoma Cares	2,748	2,651	2,466	2,481	2,373	2,307
TEFRA	292	297	307	313	320	325
SoonerPlan	20,937	21,724	22,498	22,788	23,073	23,420
Soon to be Sooners	3,099	3,132	3,103	3,041	2,979	2,955
SoonerCare Programs Total Unduplicated	**659,944**	**666,042**	**671,700**	**676,590**	**679,294**	**682,616**
Insure Oklahoma ESI	15,974	17,012	17,344	17,882	18,133	18,521
Insure Oklahoma IP	8,672	9,344	9,756	10,146	10,825	11,100
Insure Oklahoma Programs Total **Unduplicated**	**24,646**	**26,356**	**27,100**	**28,028**	**28,958**	**29,621**
Programs Total	**684,590**	**692,398**	**698,800**	**704,618**	**708,252**	**712,237**

SoonerCare Fast Facts

January 2010

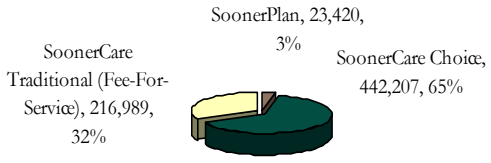
TOTAL ENROLLMENT —
OKLAHOMA SOONERCARE (MEDICAID)

Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	17,961	2.63%
Aged/Blind/Disabled	Adult	124,759	18.28%
Children/Parents	Child	450,512	66.00%
Children/Parents	Adult	45,033	6.60%
Other	Child	700	0.10%
Other	Adult	17,599	2.58%
Oklahoma Cares (Breast & Cervical Cancer)		2,307	0.34%
SoonerPlan (Family Planning)		23,420	3.43%
TEFRA		325	0.05%
Total Enrollment	**682,616**	Adults	210,050 31%
		Children	472,566 69%

OTHER Group includes—Child custody-Refugee-Qualified Medicare Beneficiary-SLMB-DDSD Supported Living-Program of All Inclusice Care for the Elderly (PACE)-Soon to be Sooners (STBS) and TB patients.
For more information go to www.okhca.org under Individuals then to Programs. Insure Oklahoma members are NOT included in the figures above.

Note that all subsequent figures are groups within the above total enrollment numbers (except Insure Oklahoma). SoonerPlan (Family Planning) members are not entitled to the full scope of benefits only family planning services are covered.

Delivery System Breakdown of Total Enrollment



Other Enrollment Facts

Unduplicated enrollees State Fiscal Year-to-Date (July through report month including Insure Oklahoma) — **806,164**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — 15,871

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — 100,153

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage—O-EPIC) is a program to assist qualifying small business owners, employees & their spouses (Employer Sponsored Insurance—**ESI**) and some individual Oklahomans (Individual Plan—**IP**) with health insurance premiums. www.insureoklahoma.org

Small Businesses Enrolled in ESI	Employees w/ ESI	Individual Plan (IP) Members
5,632	18,521	11,100

New Enrollees

Oklahoma SoonerCare members that have not been enrolled in the past 6 months.

Adults	6,687
Children	8,553
Total	**15,240**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	60,586	19,782	12%	2,783
Asian or Pacific Islander	6,745	2,810	1%	535
Black or African American	69,356	29,086	14%	2,363
Caucasian	322,582	156,184	70%	18,154
Multiple Races	13,297	2,188	2%	588
Hispanic Ethnicity	74,091	10,598	12%	4,345

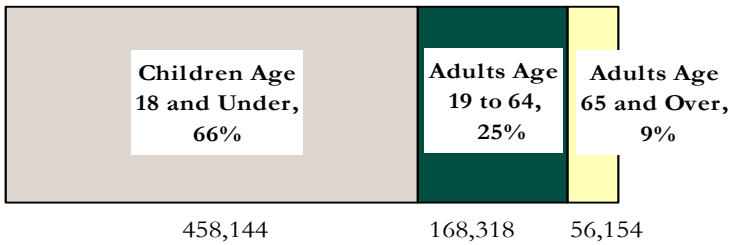
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

CHIP Breakdown of Total Enrollment

Members qualifying for SoonerCare (Medicaid) eligibility under the CHIP program are under age 19 and have income between the maximum for standard eligibility and the expanded 185% of Federal Poverty Level (FPL) income guidelines.

Age Breakdown	% of FPL	CHIP Enrollees
PRENATAL		2,955
INFANT	150% to 185%	1,393
01-05	133% to 185%	11,584
06-12	100% to 185%	33,467
13-18	100% to 185%	21,048
Total		**70,447**

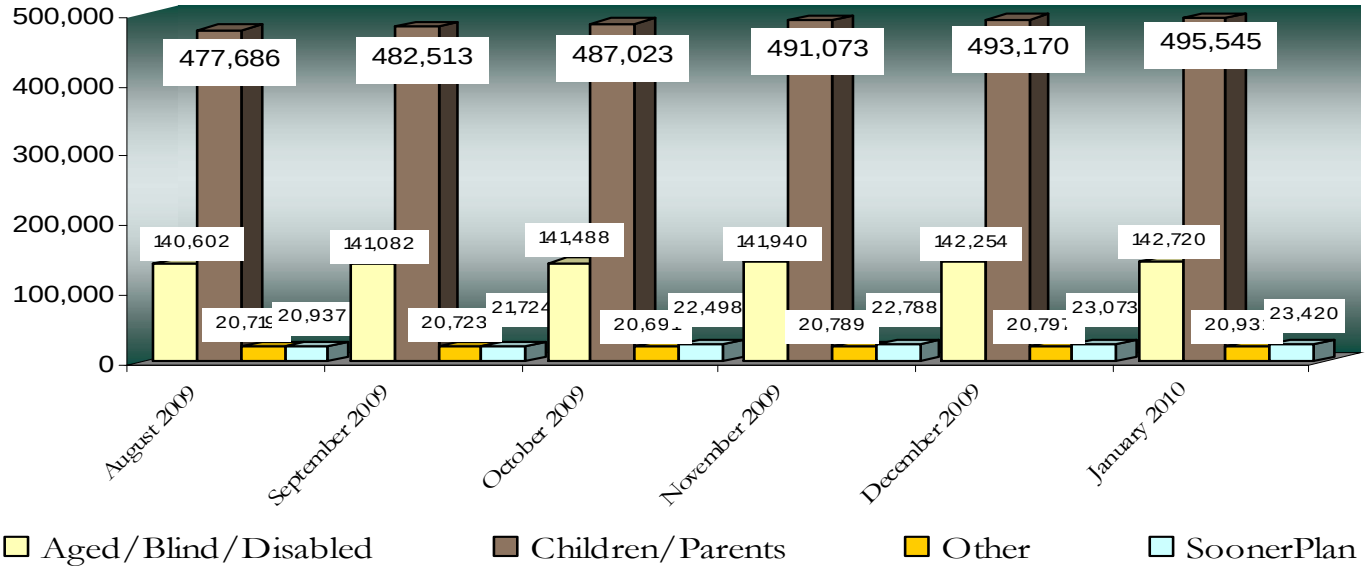
Age Breakdown of Total Enrollment



Data was compiled on 2/16/2010. Numbers frequently change due to certifications occurring after the data is extracted and other factors. This report is based on data within the system prior to 2/16/2010. A majority of the data is a "point in time" representation of the specific report month and is not cumulative. Unless stated otherwise, CHILD is defined as an individual under the age of 21.

SoonerCare Fast Facts
January 2010

Enrollment by Aid Category



State Fiscal Year is defined as the period between July 1 and June 30 of each fiscal year. Oklahoma Cares (Breast and Cervical Cancer coverage) and TEFRA are included in the OTHER category. SoonerPlan are members receiving family planning services only.

February 11, 2010

OHCA Contact: Jo Kilgore, Public Information Manager, (405) 522-7474.

SoonerCare providers will see further rate reductions

OKLAHOMA CITY – The Oklahoma Health Care Authority board approved additional reductions of 3.5 percent to rates paid to SoonerCare providers for health care services. The cuts will be added to the 3.25 percent rate reductions which were approved at the January board meeting. The latest cuts are required to accommodate the agency's reduced allocation for February through June of 2010. Both rate reductions will go into effect April 1.

The most recent reduction to the agency's budget amounts to about $12.1 million in state dollars. However, each dollar the state spends in the Medicaid program is matched by $3 from the federal government. A cut of $12.1 million state dollars creates a total cut of more than $32 million when matching federal funds are taken away.

Past actions by the board include a December meeting cut of about $17 million in state funds from the agency's budget which equaled a total reduction of $69.6 million when the federal matching funds were included. Those cuts involved reducing administrative costs, changes to durable medical equipment (DME) and prescription benefits, and changes in payments to providers for certain services. At the January meeting, a cut of $5 million in state funds, and the accompanying loss of $15 million in federal funds, was accommodated by the 3.25 percent reduction in provider rates.

"We're feeling the same pain as other state agencies," said Deputy Chief Executive Officer Nico Gomez. "But that fact doesn't make these actions any easier. Our board and agency along with state leadership has worked diligently to increase provider rates over the years. We sincerely hope that the providers will continue to work with our program through these tough economic times. More than 800,000 Oklahomans are counting on us."

The provider rate reductions will make up about $5 million of the required $12.1 million reduction. The agency's administrative budget is also being reduced by an additional $1.4 million. The remainder of cuts include: increased scrutiny of adult dental emergency extractions; reduction of Medicare crossover co-insurance and deductible to freestanding Medicaid primary end-stage renal disease (ESRD) facilities; and a reduction of 40 percent for the rate paid for diabetic supplies.

Oklahoma Health Care Authority

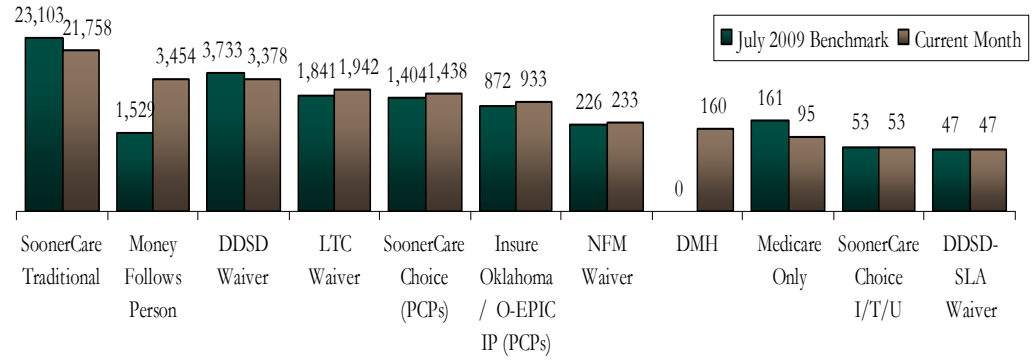
Provider Fast Facts

January 2010

Total Unduplicated Provider Count
27,466

All subsequent provider counts were derived from the total unduplicated provider count. Some providers may be counted in multiple programs.

Total Unduplicated Provider Count by Program



A group provider is a corporation that houses multiple individual providers. In order to provide a more accurate count, the group's individual providers were counted instead of the group provider.

Total Unduplicated Newly Enrolled Provider Count
229

Total unduplicated newly enrolled provider count was determined by the number of newly unduplicated provider IDs added during the month of this report.

Primary Care Provider (PCP) Capacities

SoonerCare Program Description	Total Capacity	% of Capacity Used
SoonerCare Choice	1,039,583	41.03%
SoonerCare Choice I/T/U	116,150	11.75%
Insure Oklahoma/O-EPIC IP	325,828	3.56%

Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit.

Acronyms

DDSD - Developmental Disabilities Services Division

DDSD-SLA - Developmental Disabilities Services Division-Supported Living Arrangement

DME - Durable Medical Equipment

DMH - Department of Mental Health

I/T/U - Indian Health Service/Tribal/Urban Indian

LTC - Long-Term Care

NET - Non-Emergency Transportation

NFM - Non-Federal Medical

NPI - National Provider Identifier

O-EPIC IP - Oklahoma Employer/Employee Partnership for Insurance Coverage Individual Plan

PCMH - Patient-Centered Medical Home

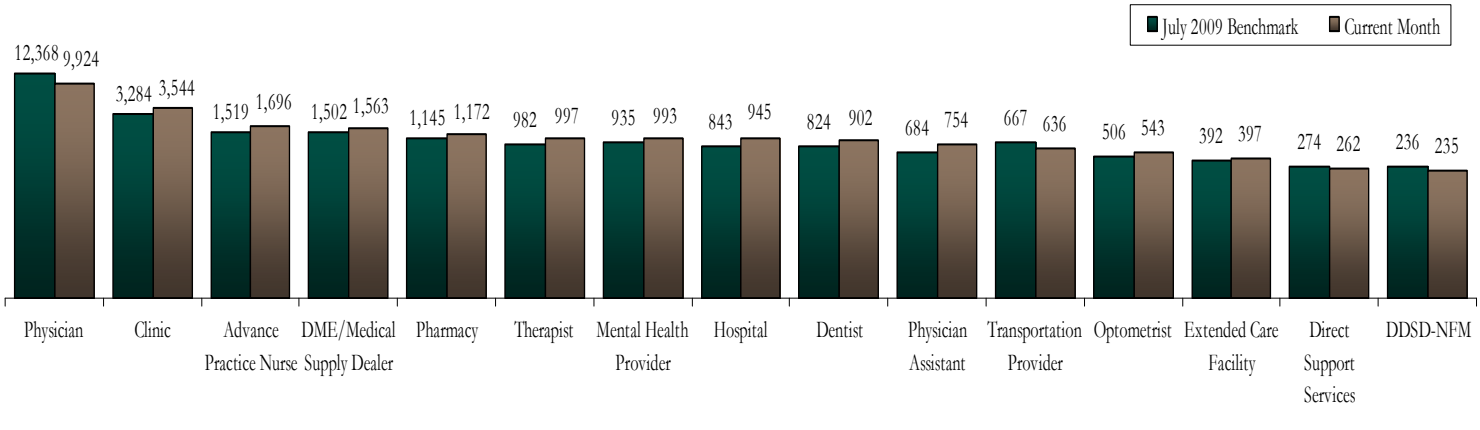
PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	490
Tier 2	225
Tier 3	46

These counts were computed using a different method than indicated elsewhere on the report and are not comparable to any other figures.

Top 15 Provider Types

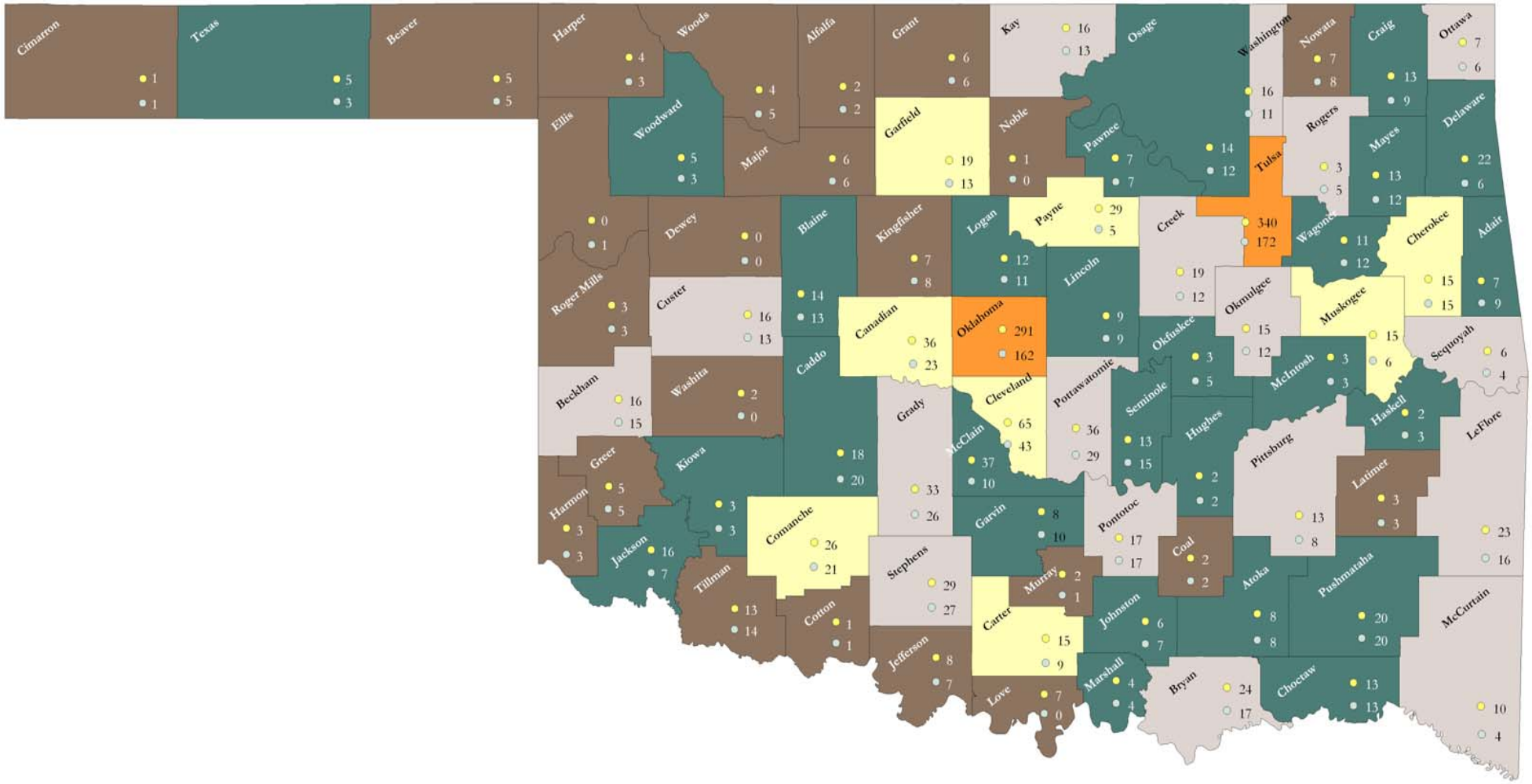


The top 15 provider types consists of the 15 provider types with the highest number of contracted providers.

Provider Fast Facts

January 2010

oklahoma health care authority



Total Provider Count

4,000 to 6,000	(2)
300 to 1,000	(8)
150 to 300	(17)
50 to 150	(27)
0 to 50	(23)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

02/16/2010

Insure Oklahoma

Fast Facts

March 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

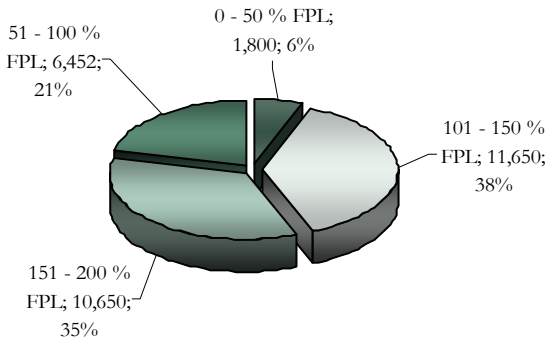
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent). The Individual Plan (IP) allows people who can't access the benefits through their employer, including those who are self-employed or may be temporarily unemployed, to buy health insurance directly through the state. Find out more information by visiting **www.insureoklahoma.org** or by calling 1-888-365-3742.

Insure Oklahoma Total Enrollment

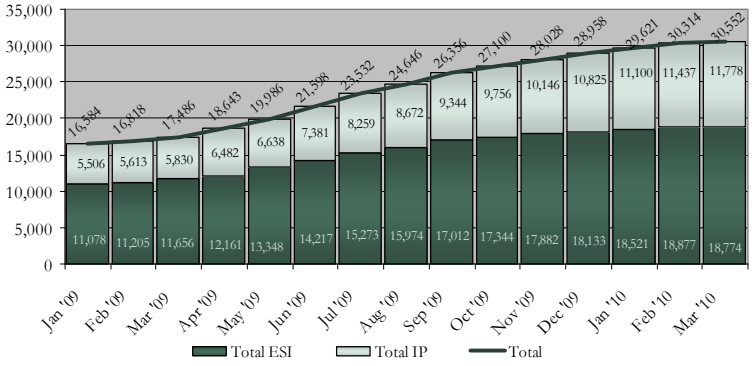
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	15,660	51.26%
Employer Sponsored Insurance (ESI)	Spouse	3,063	10.03%
Individual Plan (IP)	Employee	8,896	29.12%
Individual Plan (IP)	Spouse	2,708	8.86%
Student (ESI)	---	51	0.17%
Student (IP)	---	174	0.57%
Businesses	---	5,606	---
Carriers / HealthPlans	---	20 / 477	---
Primary Care Physician	---	963	---

Total Enrollment	**30,552**	ESI	18,774	61%
		IP	11,778	39%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment



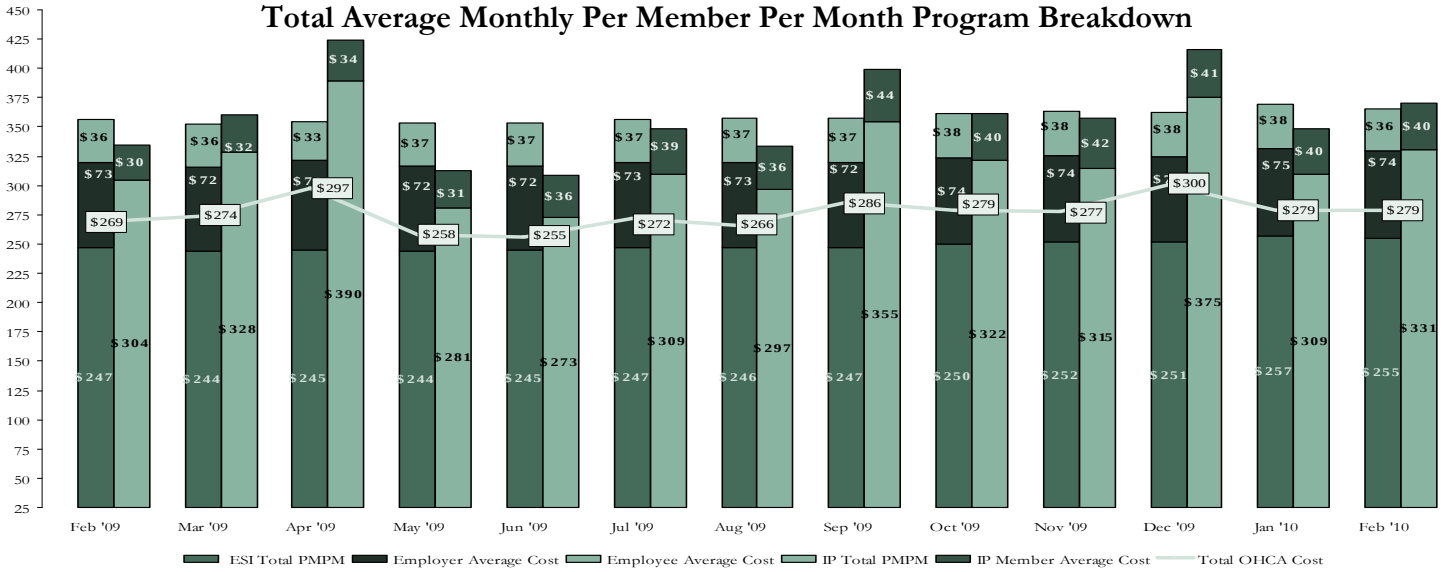
Currently Enrolled		Up from Previous Year
Businesses	5,606	36%
ESI Enrollees	18,774	61%
IP Enrollees	11,778	102%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	37,034
Call Center - Calls Answered	12,018

Call Center count now includes OHCA calls.

Total Average Monthly Per Member Per Month Program Breakdown



All the state share of the Insure Oklahoma program costs are budgeted from the state's tobacco tax revenues. (All financial information is previous month activity.)

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

3/9/2010

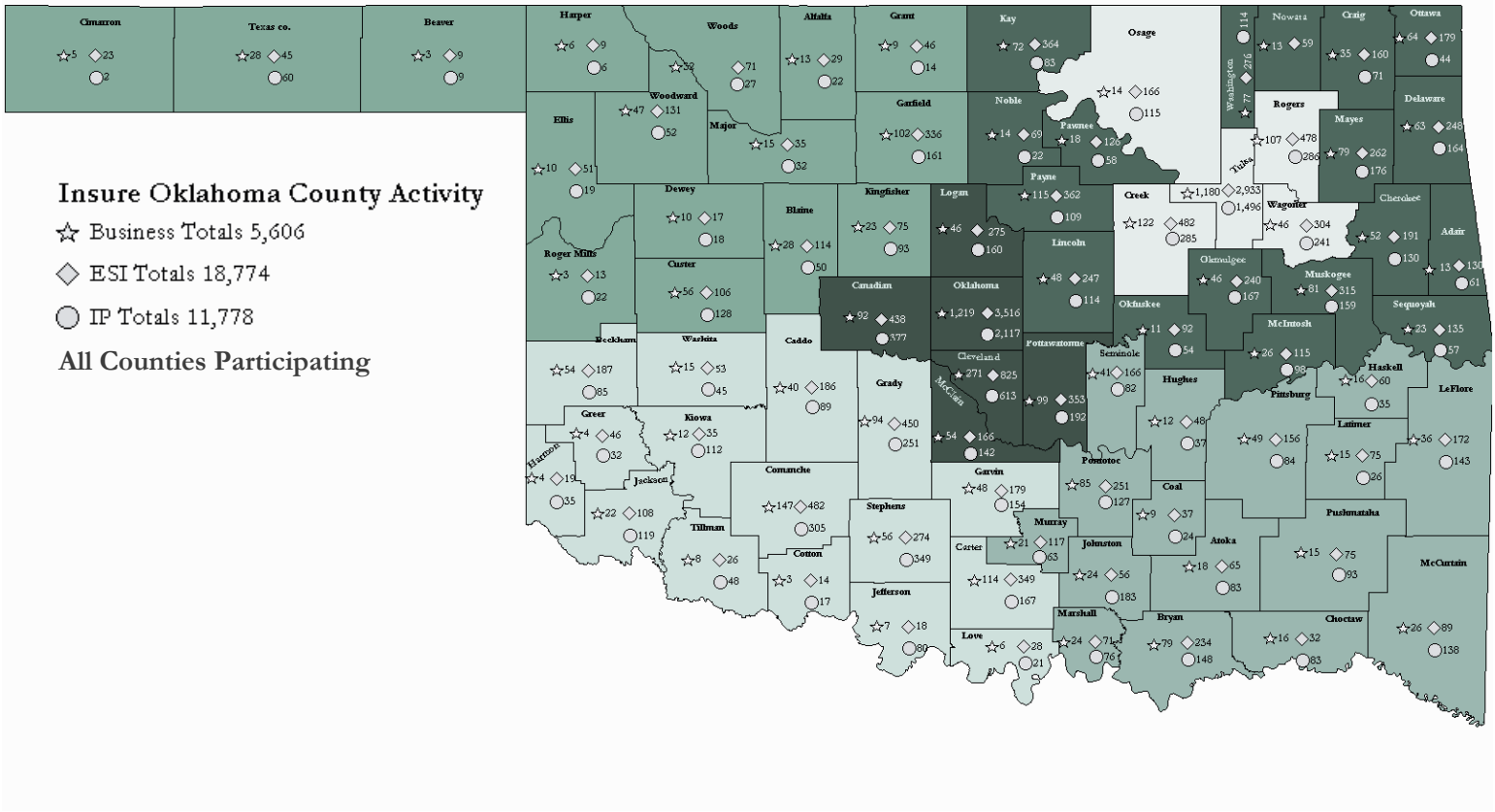
Insure Oklahoma

Fast Facts

March 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

November 2005	Oklahoma implemented Insure Oklahoma Employer Sponsored Insurance (ESI), the premium assistance for health insurance coverage targeting some 50,000 low-wage working adults in Oklahoma.
January 2007	Insure Oklahoma implements the Individual Plan (IP) to assist sole proprieetors (self employed), certain unemployed individuals, and working individuals who do not have access to small group health coverage.
November 2007	Increased Insure Oklahoma ESI qualifying income guidelines from 185 to 200 percent of the federal poverty level.
	ESI available to businesses with 25 to 50 employees.
March 2009	Expanded IP to offer coverage for full-time Oklahoma college students within qualifying income guidelines age 19 through 22.
	ESI available to businesses with 50 to 99 employees.



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3/9/2010

Employer Sponsored Insurance (ESI)

Fast Facts

March 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage-OEPIC) Employer Sponsored Insurance program is designed to assist small business owners, employees and their spouses with health insurance premiums. Find out more information by visiting **www.insureoklahoma.org**.

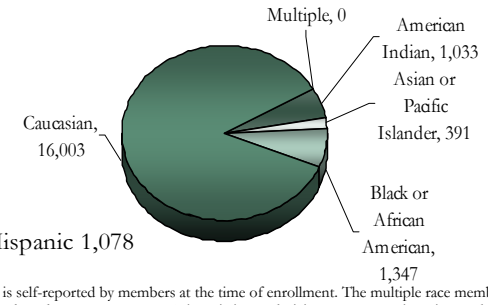
	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	7,600	8,060	**15,660**	337	389	**726**	882	755	**1,637**
Spouse	807	2,256	**3,063**	41	95	**136**	91	248	**339**
Dependent	25	26	**51**	1	0	**1**	1	1	**2**
Total	8,432	10,342	**18,774**	379	484	**863**	974	1,004	**1,978**

*Expanded income qualifications from 185 to 200% effective November 2007.

Business Activity with Employee Participation Counts				
	0 to 25	26 to 50	51 to 100	Total
Current	4,448	640	400	**5,488**
New	96	17	5	**118**
Total	**4,544**	**657**	**405**	**5,606**

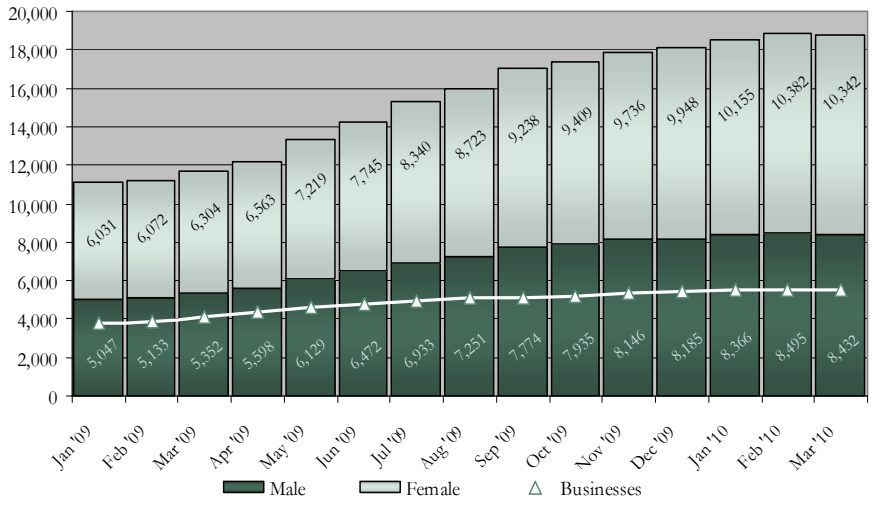
Some approved businesses may not have approved employees.

Race Breakdown of ESI Members

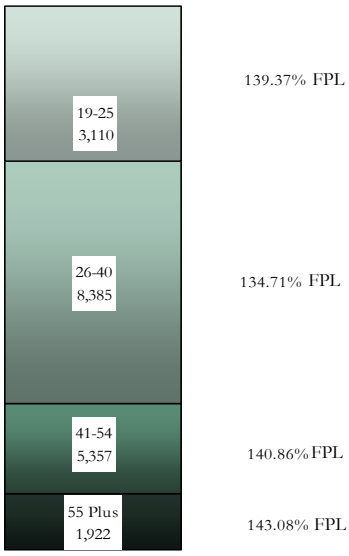


Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Member and Employer Monthly Enrollment

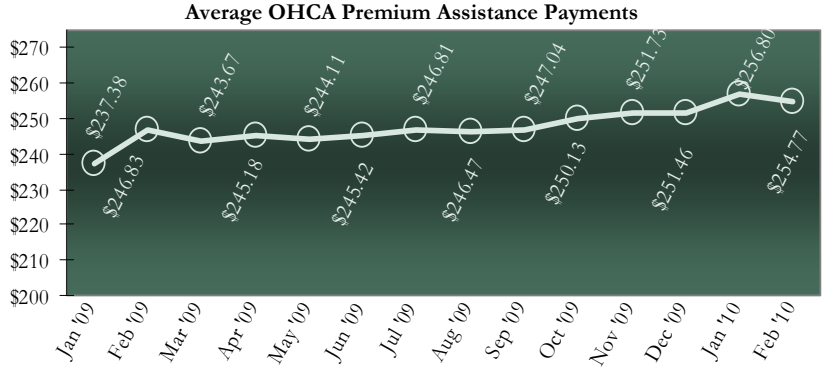


Age Breakdown with Average Federal Poverty Level of ESI Members



Federal Poverty Level is used to determine income qualification.

Average OHCA Premium Assistance Payments



Effective February 2007 OHCA Per Member Per Month reporting will be of the previous month due to semi-monthly payments verses monthly payments.

Insure Oklahoma/OEPIC ESI by Region			
	Employers	Employee/ Spouse	Participating Counties
Region 1	633	2,454	16 of 16
Region 2	390	1,110	16 of 16
Region 3	1,779	5,573	6 of 6
Region 4	1,468	4,363	5 of 5
Region 5	850	3,570	18 of 18
Region 6	486	1,704	16 of 16
Total	**5,606**	**18,774**	**77 of 77**

Regions identified on Insure Oklahoma/OEPIC Region map on next page.

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

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3/9/2010

Individual Plan (IP)

Fast Facts

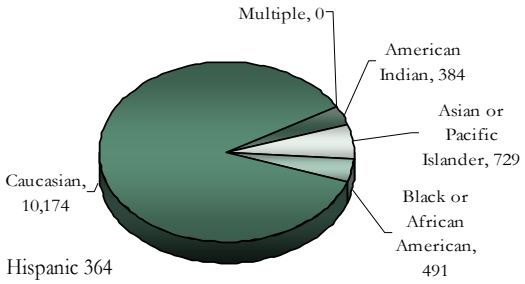
March 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage-OEPIC) Individual Plan program is designed to provide Oklahoma individuals with health insurance for themselves and their spouse if needed. It is available to Oklahomans who are not qualified for an O-EPIC employer-sponsored health plan and work for an Oklahoma small business with 99 or fewer full time employees; temporarily unemployed adults who are eligible to receive unemployment benefits through the Oklahoman Employment Security Commission; or working adults with a disability who work for any size employer and have a "ticket to work". Find out more information by visiting **www.insureoklahoma.org**.

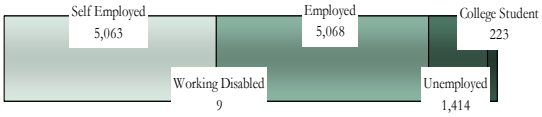
	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	4,129	4,767	**8,896**	135	218	**353**	327	313	**640**
Spouse	594	2,114	**2,708**	21	72	**93**	57	171	**228**
Dependent	68	106	**174**	3	2	**5**	6	5	**11**
Total	4,791	6,987	**11,778**	156	290	**451**	384	484	**879**

Race Breakdown of IP Members



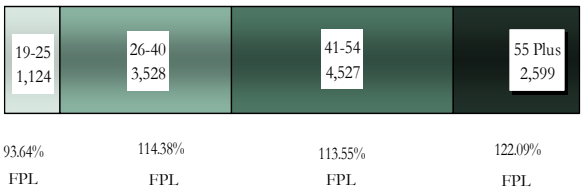
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

IP Application Type Breakdown

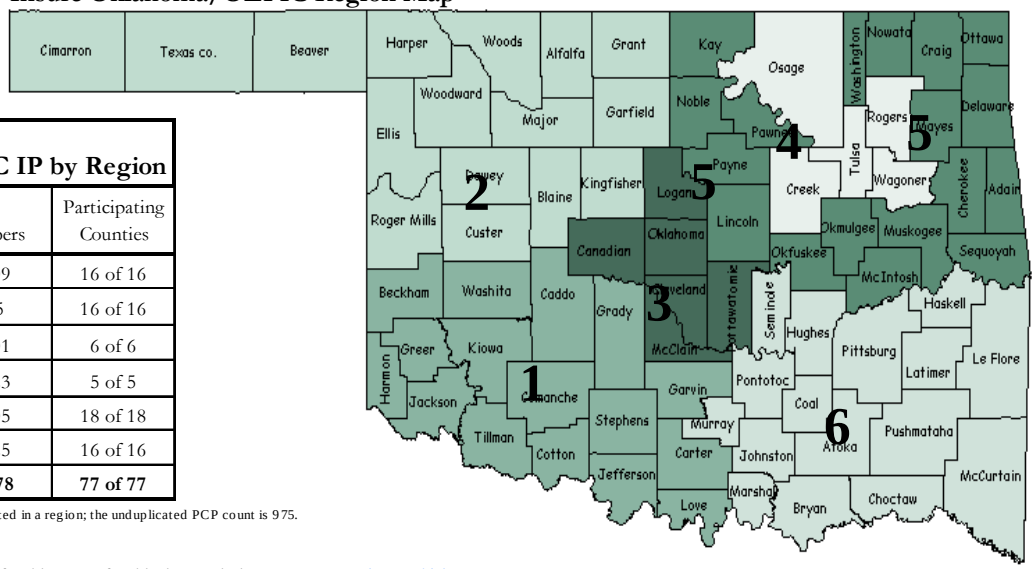


Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	15,271
IP Members Since Program Inception March 2007	18,112
Miscellaneous	
Average IP Member Premium	$54.16
Average Federal Poverty Level of IP Members	114.17%
Federal Poverty Level is used to determine income qualification.	

IP Age Breakdown with Average Federal Poverty Level for each group.



Insure Oklahoma/OEPIC Region Map



Insure Oklahoma/OEPIC IP by Region				
	PCP	Participating Counties	Members	Participating Counties
Region 1	145	15 of 16	1,909	16 of 16
Region 2	83	15 of 16	715	16 of 16
Region 3	244	6 of 6	3,601	6 of 6
Region 4	222	5 of 5	2,423	5 of 5
Region 5	148	17 of 18	1,705	18 of 18
Region 6	121	16 of 16	1,425	16 of 16
Total	**963**	**74 of 77**	**11,778**	**77 of 77**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 975.

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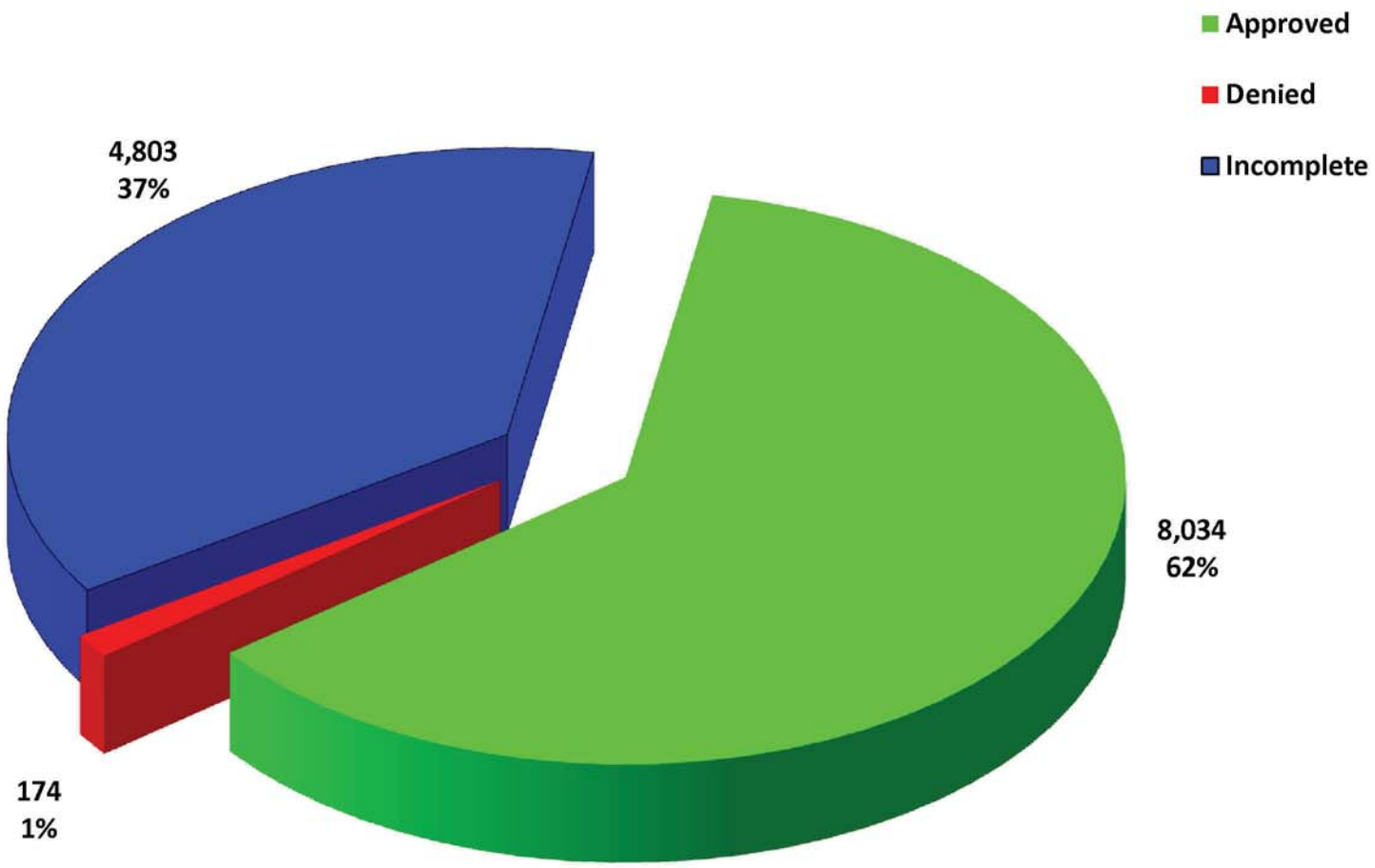
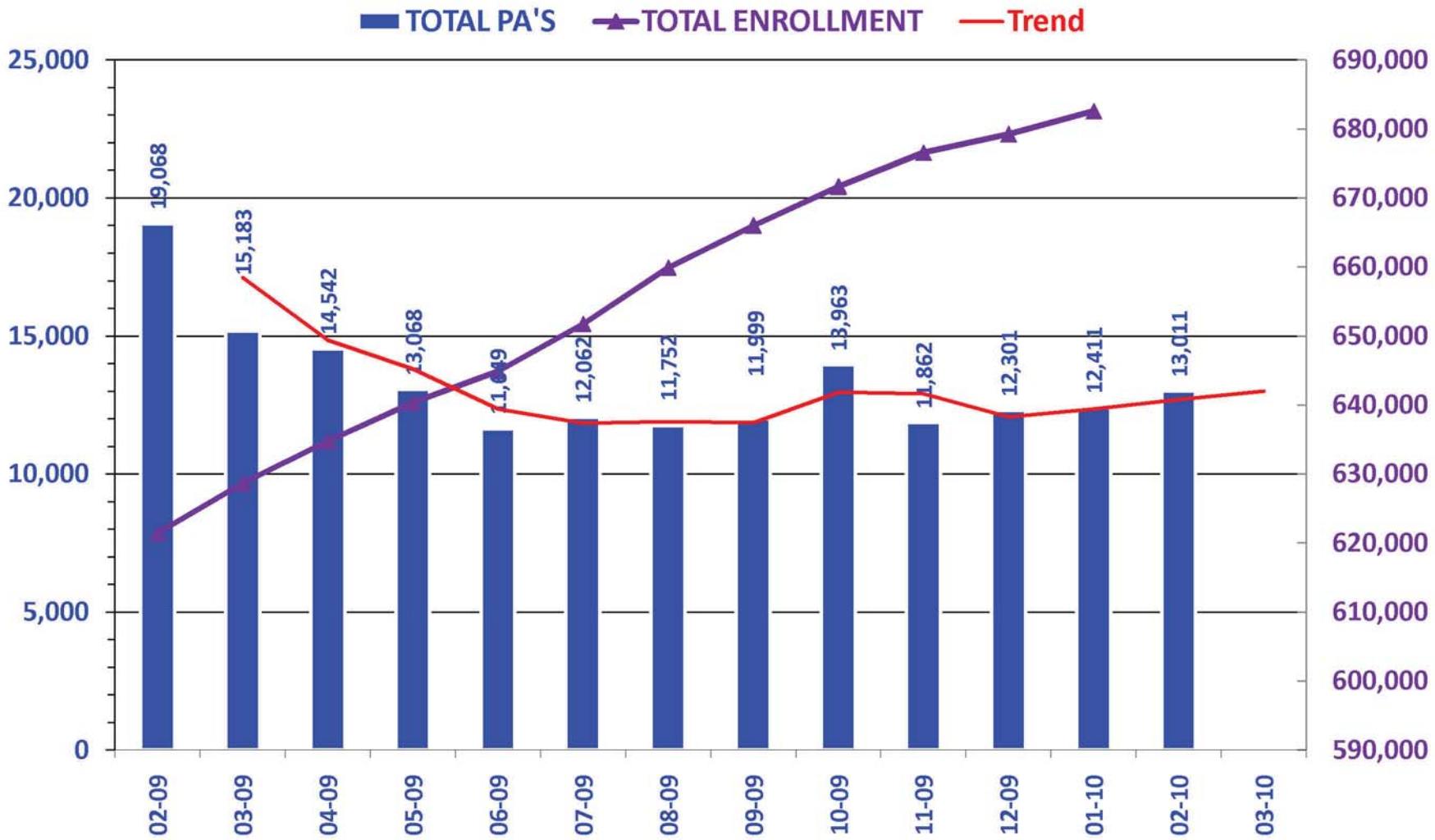
3/9/2010

PRIOR AUTHORIZATION ACTIVITY REPORT: February 2010



PA totals include overrides

PRIOR AUTHORIZATION REPORT: February 2009 – February 2010



PA totals include overrides

Prior Authorization Activity

February 2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	517	270	2	245	357
Amitiza	25	9	0	16	269
Antidepressant	417	125	1	291	340
Antihistamine	323	172	0	151	286
Antihypertensives	139	53	0	86	338
Antimigraine	132	24	0	108	199
Benzodiazepines	4,577	3,985	11	581	89
Bladder Control	90	17	4	69	339
Byetta	13	2	0	11	364
Elidel/Protopic	40	23	1	16	88
ESA	156	120	2	34	56
Fibric Acid Derivatives	7	0	0	7	0
Fibromyalgia	170	60	3	107	334
Forteo	5	2	0	3	353
Glaucoma	29	6	0	23	362
Growth Hormones	44	36	3	5	155
HFA Rescue Inhalers	92	43	0	49	276
Insomnia	120	30	2	88	126
Misc Analgesics	56	10	19	27	144
Muscle Relaxant	187	72	54	61	46
Nasal Allergy	449	50	2	397	170
NSAIDS	167	39	6	122	218
Nucynta	3	2	0	1	47
Ocular Allergy	16	1	0	15	364
Ocular Antibiotics	24	7	0	17	13
Opioid Analgesic	184	85	4	95	171
Other	564	240	17	307	139
Otic Antibiotic	165	64	0	101	24
Pediculicides	77	29	2	46	17
Plavix	123	99	0	24	360
Proton Pump Inhibitors	641	98	4	539	98
Qualaquin (Quinine)	2	0	1	1	0
Singulair	690	355	1	334	276
Smoking Cessation	84	25	2	57	56
Statins	112	21	1	90	349
Stimulant	945	613	5	327	234
Symlin	2	1	0	1	364
Synagis	153	119	9	25	45
Topical Antibiotics	25	6	0	19	28
Topical Antifungals	30	7	0	23	24
Ultram ER and ODT	9	1	0	8	364
Xolair	2	1	0	1	358
Xopenex Nebs	48	25	0	23	231
Zetia (Ezetimibe)	30	23	0	7	360
Emergency PAs	0	0	0	0	
Total	**11,684**	**6,970**	**156**	**4,558**	

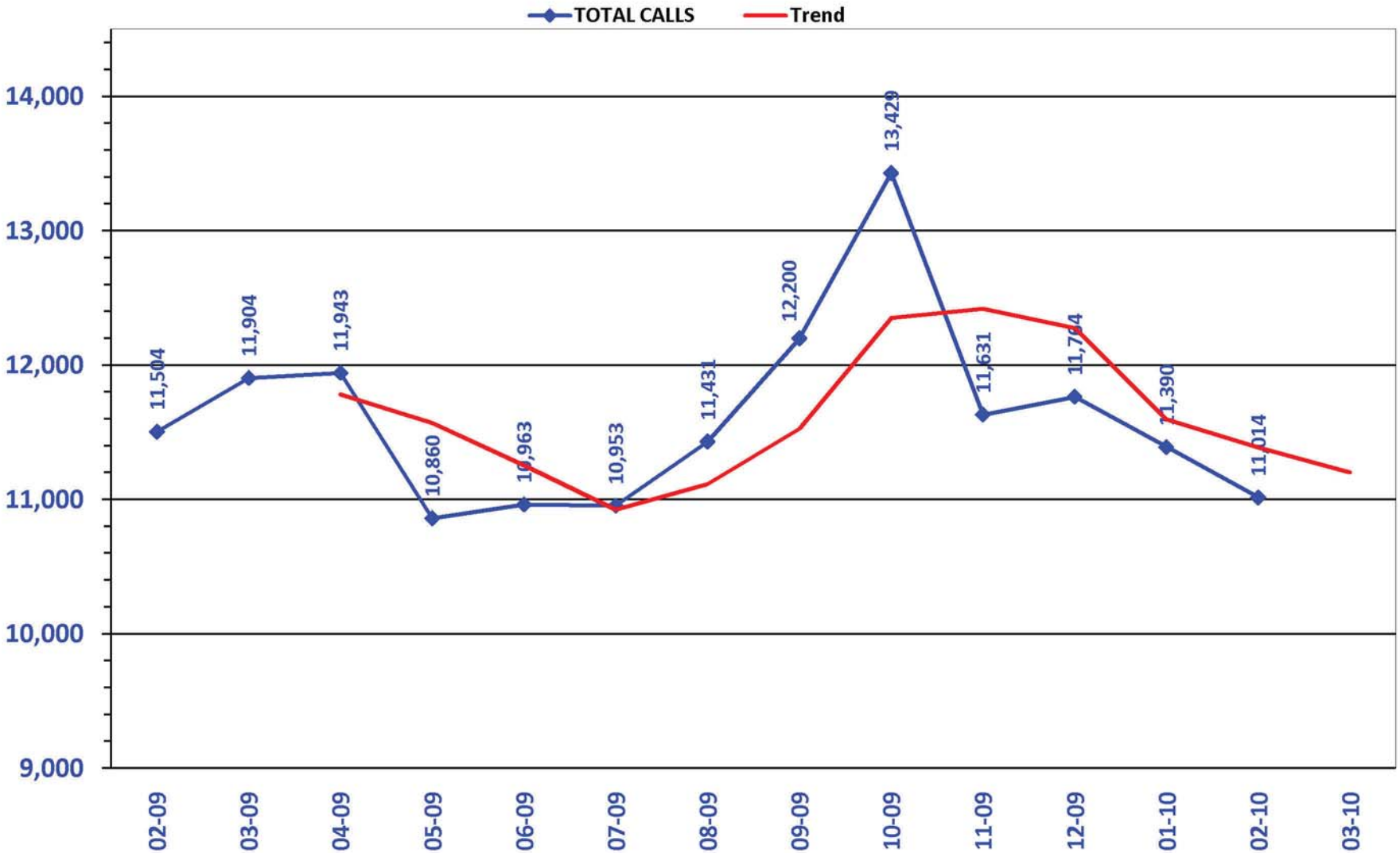
Overrides					
Brand	113	94	1	18	182
Dosage Change	454	422	5	27	17
High Dose	2	0	0	2	0
IHS - Brand	80	67	0	13	102
Ingredient Duplication	7	6	0	1	22
Lost/Broken Rx	72	67	1	4	17
Nursing Home Issue	71	62	1	8	15
Other	20	19	0	1	32
Quantity vs. Days Supply	505	325	9	171	238
Stolen	1	0	1	0	0
Wrong D.S. on Previous Rx	2	2	0	0	360
Overrides Total	**1,327**	**1,064**	**18**	**245**	
Total Regular PAs + Overrides	**13,011**	**8,034**	**174**	**4,803**	

Denial Reasons	
Lack required information to process request.	2,326
Unable to verify required trials.	1,881
Does not meet established criteria.	202
Not an FDA approved indication/diagnosis.	166
Member has active PA for requested medication.	160
Considered duplicate therapy. Member has a prior authorization for similar medication.	114
Requested dose exceeds maximum recommended FDA dose.	68
Medication not covered as pharmacy benefit.	21
Drug Not Deemed Medically Necessary	4

Duplicate Requests: 849

Changes to existing PAs: 817

CALL VOLUME MONTHLY REPORT:
February 2009 – February 2010



OHCA BOARD MEETING

MARCH 11, 2010 OHCA BOARD MEETING

OHCA REQUEST BILLS:

- SB 1349 – Obesity Treatment Pilot Program for Medicaid
- SB 1836 - Health Information Infrastructure Advisory Board to Assist OHCA In Developing Electronic Health Record Incentive Payments

After the February committee deadlines, and as of noon, Thursday, March 4th, 2010, the Oklahoma Legislature is currently tracking a total of 1,563 active bills. OHCA is currently tracking 100 bills. They are broken down as follows:

- OHCA Request 02
- Direct Impact 29
- Agency Interest 11
- Appropriations 11
- Employee Interest 12
- Carry Over 34
- Governor Signed 01

March 11, 2010, is the deadline for Third Reading of bills or joint resolutions in the House of Origin (House/Senate). The next deadlines are Thursday, April 1st for reporting House Bills and Joint Resolutions from Senate Committees and Thursday, April 8th for reporting Senate Bills and Joint Resolutions from House Committees.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Physicians

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for the Physicians fee schedule. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following methodology change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

REVIEW OF RATES

Oklahoma has adopted the Medicare Resource Based Relative Value Scale (RBRVS) methodology as a benchmark for establishing fee-for-service payments to physicians and other limited licensed practitioners who bill the same as physicians. The general formula for calculating the rate multiplies a relative value unit (RVU) by a conversion factor (CF). Oklahoma currently pays 100% of the 2009 Medicare physician fee schedule, which is the upper payment limit for services approved by the Center for Medicare and Medicaid Services (CMS). The current CF is **$36.066**. In order to improve access to specialty care, state employed physicians are paid 140% of the 2009 Medicare CF.

- Anesthesiologists are paid a market based rate; (CF = $31.50 compared to Medicare of $16.61 for 2010)
- Payment for physician administered drugs is based on the Medicare methodology.
- Rates for other services and supplies not included in the RBRVS methodology have specific rates established by OHCA based on factors such as salaries and wages, and

market prices or maximum allowable approved by CMS

Staff reviewed a comparison of Oklahoma payment rates at 100% compared to a national ratio of **66%.** (**See Appendix A)**

AGENCY RECOMMENDATION: A 3.25% reduction to the rates should not impact access to care.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $13,824,806; $4,917,483 state share.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

APPENDIX A

Medicaid-to-Medicare Fee Index for Primary Care, 2008

State	Ratio
Alaska	140.00%
Wyoming	117.00%
Idaho	103.00%
North Dakota	101.00%
Delaware	100.00%
Oklahoma	100.00%
New Mexico	98.00%
Arizona	97.00%
Montana	96.00%
North Carolina	95.00%
Kansas	94.00%
Nevada	93.00%
Washington	92.00%
Vermont	91.00%
Louisiana	90.00%
Iowa	89.00%
Virginia	88.00%
Colorado	87.00%
Georgia	86.00%
South Carolina	86.00%
South Dakota	85.00%
Mississippi	84.00%
Maryland	82.00%
Nebraska	82.00%
Kentucky	80.00%
Alabama	78.00%
Arkansas	78.00%
Connecticut	78.00%
Massachusetts	78.00%
Oregon	78.00%
West Virginia	77.00%
Utah	76.00%
Texas	68.00%
New Hampshire	67.00%
Wisconsin	67.00%
Ohio	66.00%
Missouri	65.00%
Hawaii	64.00%
Pennsylvania	62.00%
Indiana	61.00%
Michigan	59.00%
Minnesota	58.00%
Illinois	57.00%
Florida	55.00%
Maine	53.00%
California	47.00%
District of Columbia	47.00%
New Jersey	41.00%
New York	36.00%
Rhode Island	36.00%
U.S. Average	**66.00%**
Tennessee	n/a

Source: Health Care Reform Moves Forward, Includes Big Changes to Medicaid Federal Funds Information to States, 444 N. Capitol St., NW, Suite 642, Washington, DC 20001 ISSUE BRIEF 10-01. 1/7/2010

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Hospitals (Inpatient)

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for Inpatient Hospitals. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

REVIEW OF RATES

Inpatient hospital services are paid based on a prospective Diagnosis Related Group (DRG) methodology or a per diem system. DRG base rates are based on allowable costs computed from CMS cost reports for the last three years. The general formula for a DRG payment = DRG relative weight x Hospital base rate + outlier adjustment. DRG weights and rates were last updated January 1, 2010. .

Since October 1, 2005 reimbursement for all Freestanding Rehabilitation Hospitals has been made through a prospective rate. The rate is the sum of the statewide median for the capital and operating components of all like facilities and has been up-dated for inflation. The only exception is that the Valir Rehabilitation Hospital rate was up-dated to $869.33, the estimated cost for the period beginning 05-01-09. The rate was established to cover the increased costs of this facility because of its' unique relationship with the Oklahoma Medical Center, accepting patients from that facility at a lower cost and more appropriate care setting.

Since May 01, 2000 reimbursement for all Children's Sub-Acute Long Term Care Hospitals been made through a prospective rate. The rate was set at 85.7% of the existing statewide median rehab level of care per diem rate. Currently, the Children's Center located in Bethany, Oklahoma, is the only facility of this type contracting with the OHCA. For the period beginning 05-01-09 the rate was set at the estimated allowable cost of $537.40 per day.

Per diem rates for freestanding psychiatric hospitals were last updated 1/1/08. The current rate is $617.51 per day.

AGENCY RECOMMENDATION

We compared all hospital payments to aggregate allowable costs and to the Medicare DRG payment methodology for all classes of facilities (private, non-state government and government) as required by federal regulations. A 3.25% decrease to the current DRG hospital base rates and to the level of care per diems for rehabilitation, freestanding psychiatric and long term care hospitals serving children should not impact access and quality of care.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $19,903,856; $7,079,802 state share.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Outpatient Hospital and Clinic Services

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for outpatient hospital and clinic services. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

REVIEW OF RATES

A. **Outpatient Hospital Services**: Outpatient hospital services include emergency room services, ambulatory surgery services, and observation, dialysis and chemotherapy treatment services. Payments are made based on the Medicare reimbursement schedules or allowable costs. (The upper limits).

B. **Clinic Services** means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(a) Services furnished at the clinic by or under the direction of a physician or dentist.
(b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing.

Clinics include the following:

1) **Federally Qualified Health Centers and Rural Health Clinics, Indian Health Clinics; Public Health Clinics (county health departments), State Operated and Private Community Mental Health Clinics (CMHCs):** Safety net providers in that they all serve low income, medically underserved and vulnerable populations that traditionally have limited access to affordable services and face the greatest barriers to care. Rates for FQHCs, RHCs and IHS clinics receive federal funding to provide access to the uninsured and rates are established by federal law. Other clinics rely on state appropriations from the legislature to provide access to uninsured. Payments to other clinics are limited to 100% of the Medicare fee schedule. Payment is for professional services only.

2) **Other Clinics: Freestanding Ambulatory Surgery Centers, Freestanding End Stage Renal Dialysis Facilities, Independent Diagnostic Testing Facilities.** In addition to payment for professional services, the clinics in this section receive a facility fee**.** Services are paid up to 100% of the Medicare RBRVS fee schedule

Agency Recommendation: We compared the payments to the Medicare fee schedules and allowable costs for outpatient hospital and clinic services; a 3.25% decrease to the rates should not negatively impact access and quality of care to SoonerCare members. There are no cuts to the PPS rates for FQHCs or RHCs, and the OMB rates for IHS clinics.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $$6,646,147; $2,364,034 state share for care Outpatient Hospitals, and $2,956,704; $1,051,700 state share for clinic services.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Inpatient Psychiatric Services for Individuals Under Age 21
and Community-Based Alternatives

ISSUE

The Oklahoma Health Care Authority (OHCA), Finance Division recommends a revision to the current rates and reimbursement structure for residential treatment provided by psychiatric units of general medical/surgical hospitals, psychiatric hospitals and psychiatric residential treatment facilities (PRTFs). The OHCA is proposing recalculation of the current per diems along with a tiered reimbursement methodology that declines based on length of stay. These changes are being made in order to encourage discharge to more appropriate community alternatives than residential placement.

BACKGROUND

Beginning October 2005, the OHCA implemented all-inclusive payment rates for residential psychiatric services based on facility and patient characteristics (peer groups). In addition to room and board, the rates include professional and prescription drugs as well as any other medical required during the inpatient stay. This rate change was the result of an audit by the Centers for Medicare and Medicaid Services (CMS) of services paid outside the per diem rate, while a child was an inpatient in an Institution for Mental Diseases (IMD)[1]. Rates were last updated effective January 1, 2008. Current rates vary based on facility and patient characteristics and range from $330 to $413 per day for in-state providers. The average length of stay is 70 days.

According to a September 2009 report by Mathematica Policy Research, Inc., "the primary source of behavioral health expenditure growth in Oklahoma in recent years has been Psychiatric Residential Treatment Facility (PRTFs) services for children. Expenditures for these PRTFs have grown from $58 million in SFY06 to $112 million in SFY09, and now account for over 45 percent of all Medicaid behavioral health expenditures for children." The report further stated that "while a very small number of children may require mental health services in PRTFs when there is an immediate need that cannot be met in a less restrictive setting, there is now a consensus among providers, researchers, and family advocates that stays in PRTFs should be short-term with the goal of family preservation and timely integration back into the community. There is little evidence that stays in PRTFs result in long-term gains in functioning"[2]

Mathematica recommended that OHCA revise PRTF reimbursement in ways that would both contain costs and improve performance, including reducing the per diem rate for longer lengths of stay. Linking reimbursement levels more closely to actual service needs would increase PRTF incentives to participate actively in discharge planning.

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[1] CMS cited Public Law 100-360 of 1988 which defines an IMD as a hospital or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. If the institution is licensed as a psychiatric facility, CMS considers the institution an IMD. The audit determined that OHCA should not claim Federal Financial Participation (FFP) for services paid outside the per diem.

[2] SoonerCare Behavioral Health Expenditure Recommendations, Mathematica Policy Research, September 2009,

Eligible Providers of Inpatient Psychiatric Services and Staffing

Federal regulations at 42 CFR 440.160 specify that inpatient psychiatric services are provided by:

> 1) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or
>
> (2) A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.

In addition to the above requirements, residential services that are provided by a medical/surgical unit of a hospital must meet licensure requirements for hospitals specified by the state, which requires RN staffing 24 hours per day. OHCA rules require other programs to be licensed by the Oklahoma Department of Human Services as a residential child placing agency - the minimum staffing ratio is 1:6 during waking hours. OHCA rules require higher staffing ratios of 1:3 for neurodevelopmental disorder programs.

UPDATES TO PER DIEM RATES

The current rates for residential services are peer grouped as follows: specialty unit per diem for neurodevelopmental disorder programs, hospital-based programs, freestanding/standard programs, community-based extended and community based transitional. We are proposing to recalculate the current rates, implementing a 3.25% reduction due to the increased volume since 2006, with the following methodology: **1)** a standard rate for staff secure residential programs that meets the minimum staffing and resources for child placing agency licensure - with a tiered approach that declines after the first 45 days; **2)** a facility differential due to the higher intensity staffing required by physically secure/locked facilities and to further recognize the higher costs inherent in hospital based programs (RN staffing and overhead allocations for services such as dedicated emergency departments) with rates that also declines after 45 days; **3)** a new peer group payment for sexual offender programs (these programs require separate units from the general population for treatment); **4)** and new per diem rates for eating disorder programs (we are unable to contract with any instate providers for this service). This will allow for a short-term extended stay for the resident until ready for outpatient programs. To encourage proactive discharge planning, we recommend that the rates be reduced for days 46-90 by 10% and for days 91+ by an additional 5% for **the standard and restrictive/secure programs**.

Behavior and developmental disorder programs generally have higher costs due to the required higher staffing ratios and costs of prescription drugs and other medical services, and generally are longer term residential programs. No additional reduction in the rates is recommended after this change in the current base rates for specialty units and sexual offender programs.

Determination of Proposed Base Rates

The proposed rates for all residential programs are calculated based on a standard overall reduction of 3.25% to the current base rates. We reviewed rates paid by other states, cost report data, surveys and other relevant factors, and recommend the following base rates:

Peer Group/	Licensure Standard	New Base Rates	Current Rates	%Chg
Standard (default)	Child Placing	**$319.54**	$330.27	-3.25%
Restrictive / Secure	Child Placing	**$336.57**	$347.88	-3.25%
Restrictive / Secure	Hospital	**$345.05**	$356.64	-3.25%
Sexual Offender	Child Placing	**$336.57**	$347.88	-3.25%
Sexual Offender	Hospital	**$345.05**	$356.64	-3.25%
Neurodevelopmental	Child Placing	**$400.05**	$413.49	-3.25%
EatingDisorders/TBI	Hospital	**$432.26**	None	100%

ALTERNATIVE SERIVICES

PRTFs with 16 beds or fewer
We are also proposing an increase to the current rate for services defined as "community-based transitional" (CBT) programs, due to a market survey that indicates that the current rate of $190.97 per day is not sufficient to enlist enough providers. The CBT offers a more family like program in a less restrictive environment. In addition to the per diem, separate payment may be made for professional and ancillary services, as these facilities are not IMDs. The proposed per diem is **$220** per day.

Partial Hospitalization
The number of children accessing residential treatment has increased from 3,425 in SFY06 to 4,180 in SFY09. Partial Hospitalization is a short-term, structured outpatient day program that is highly intensive but does not require 24 hour service. The addition of partial hospitalization day program services will allow for an appropriate continuum on an outpatient basis. The recommended hourly rate of $42.80 is based on the Medicare per diem method for a maximum of 4 units of service per day. The proposed effective date is based on available funding.

The actual changes we are proposing are shown in Attachment A.

ADEQUACY OF PAYMENT RATES

Section 1902 (a)(30)(A) of the Social Security Act ("the Act") requires that state payment rates are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available to the extent that such care and services are available to the general population in the geographic area. We believe these changes are consistent with this requirement,

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $7,783,187 million; $2,768,480 million state share.

EFFECTIVE DATE

The effective date of these changes in residential rates is April 1, 2010.

Attachment A

Service	Unit	Hospital Rate	Non-Hospital Rate
Residential Treatment: Non-Secure			***$ 330.27***
Days 1-45	Per Diem		**$ 319.54**
Days 46-90	Per Diem		**$ 287.58**
Days 91 +	Per Diem		**$ 273.20**
Includes residential TBI & Speicalty stepdown programs. Rates are all-inclusive			
Residential Treatment : Restrictive/Secure		***$ 356.64***	***$ 347.88***
Days 1-45	Per Diem	**$ 345.05**	**$ 336.57**
Days 46-90	Per Diem	**$ 310.54**	**$ 302.92**
Days 91 +	Per Diem	**$ 295.02**	**$ 287.77**
Rates are all-inclusive			
Specialty: Sexual Offender		***$ 356.64***	***$ 347.88***
Days 1-45	Per Diem	**$ 345.05**	**$ 336.57**
Days 46-90	Per Diem	**$ 345.05**	**$ 336.57**
Days 91 +	Per Diem	**$ 345.05**	**$ 336.57**
Rates are all-inclusive			
Other Specialty		***$ -***	***$ 413.49***
Days 1-45	Per Diem	**$ 432.26**	**$ 400.05**
Days 46-90	Per Diem		**$ 400.05**
Days 91 +	Per Diem		**$ 400.05**
Hospital specialty includes: neuropsychiatric dx, Eating disorders and TBI. Non-hospital specialty programs include RAD; ASD; MR/MI. Rates are all-inclusive			
Residential Treatment (16 beds or less)		***$ 190.97***	***$ 190.97***
Transitional (CBT) MH	Per Diem	**$ 220.49**	**$ 220.49**
Partial Hospitalization			
Max 4 units per day	Per Hour	**$42.80**	

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
SoonerCare Choice Coordination and Incentive Payments

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for Care Coordination for SoonerCare Choice Management services. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following methodology change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

PROPOSED METHODOLOGY

Sooner Care Choice primary care practitioners are paid a Per Member Per Month (PMPM) fees for medical home care coordination activities. (Fees range from $3.03 to $8.69 PMPM). The OHCA has a SoonerCare Choice performance based reimbursement component that recognizes achievement of excellence in improving quality and providing effective care.

AGENCY RECOMMENDATION

A 3.25% cut to the care coordination fees and incentive payments**.**

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $758,161; $269,678 state share for care coordination fees, and $146,250; $52,021 state share for incentive payments.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Home Health Care and Hospice

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for Home Health Care, and Hospice. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below

REVIEW OF RATES

Current SoonerCare Rates

- **Home Health**

  Home Health Aide - **$ 33.17 per visit**
  Skilled Nursing - **$ 73.25 per visit**

According to a 2008 Kaiser Commission report, the average reimbursement that states provided to home health agencies was $71.98 per home health visit in 2007. In states that paid registered nurses (RNs) or home health aides (HHA) directly or mandated their reimbursement rates, the average rate for RNs was $79.95 per visit and $38.95 per visit for HHAs. http://www.kff.org/medicaid/upload/7720_02.pdf

Hospice – Payment is based on 100% of Medicare fee schedule**.**

AGENCY RECOMMENDATION: Reduce rates for home health, and hospice by 3.25%.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $668,475; $237,777 state share.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Medical or Other Remedial Care by Limited License Practitioners;
Lab and X-Ray Services

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for Practitioners. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following methodology change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

REVIEW OF RATES

Oklahoma has adopted the Medicare Resource Based Relative Value Scale (RBRVS) methodology as a benchmark for establishing fee-for-service payments to physicians and other limited licensed practitioners who bill the same as physicians. The general formula for calculating the rate multiplies a relative value unit (RVU) by a conversion factor (CF). Oklahoma currently pays 100% of the 2009 Medicare physician fee schedule, which is the upper payment limit for services approved by the Center for Medicare and Medicaid Services (CMS). The current CF is **$36.066.** Practitioners include but may not be limited to:

- Advance practice Nurses and Certified Pediatric Nurse Practitioners;
- Chiropractors;
- Nurse Midwives
- Optometrists

- Nutritionists
- Physician assistants
- Physical and Occupational therapists
- Psychologists
- Speech therapists and Audiologists
- CRNAs (80% of Anesthesiologists**)**

Laboratory Services: Payment cannot exceed 100% of the Medicare lab fee schedule. Currently services are paid at 95% of lab fee schedule.

X-Ray Services: Paid at 100% of Medicare fee schedule

Other Services: Rates for other services and supplies not included in the RBRVS methodology have specific rates established by OHCA based on factors such as salaries and wages, and market prices or maximum allowable approved by CMS.

AGENCY RECOMMENDATION: A 3.25% reduction to the rates should not impact access to care.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $1,570,353; $558,574 state share for other practitioners. The annual change for lab and radiology is $956,234; $340,132 state share.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Emergency Transportation

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for emergency transportation services. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

REVIEW OF RATES

Ground and Rotary Wing base rates and mileage are based on 2005 Medicare.

AGENCY RECOMMENDATION: 3.25% reduction in transportation fees.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $1,214,821; $432,112 state share.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Proposed Reimbursement for Regular Nursing Facilities

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for the Regular Nursing Facilities. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

Under the State Plan as amended to meet the requirements of Title 56, §1011.5 and Title 63, §1928 of the Oklahoma Statutes, nursing facilities are paid in the following manner. A facility specific rate is established for each home that is the combination of four components. The four components are:

- Base Rate Component
- Focus on Excellence Performance Measure Component
- Direct Care Component
- Other Costs Component

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following methodology change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

PROPOSED METHODOLOGY

No change is being proposed in the methodology to establish the rate components. Under the current methodology the rate components are established each period from the estimate of Medicaid days and the total available funds. Under the newly approved operation plan the following will occur:

- The base rate component will remain at $103.20 as required by legislation.
- The component amount awarded for a point earned under the Focus on Excellence program will change to $1.09 per patient day (PPD) from $1.10 PPD.
- The Other Costs Component will change to $6.03 PPD from $7.05 PPD
- The average Direct Care Component will change to $14.08 PPD from $16.45 PPD.
- The range of total rates from this re-allocation will change to a range of $117.84 to $132.39 from a rate range of $120.22 to 136.67.

OHCA staff recommends that approval to amend the available funds and re-allocate the rate components be approved. The total funds available from all sources will change from $637,539,838 to $620,611,837.

Access to services should not be disrupted because at the current time the overall occupancy rate for this facility type is 68%.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $16,928,001, $6,021,290 in appropriated state share. The overall rate change is 2.65% because of the effect of the patient spend-down of 19.14% on the available funds.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

OKLAHOMA HEALTH CARE AUTHORITY
SFY 2010 BUDGET
TIERED REIMBURSEMENT

3/1/2010

95.0 % Participating			
0 point Facilities	**At 0.0%**	**0.0414**	**0.0000**
1 to 2 point Facilities	**At 1.0%**	**0.2103**	**0.0021**
3 to 4 point Facilities	**At 2.0%**	**0.2759**	**0.0055**
5 to 6 point Facilities	**At 3.0%**	**0.3069**	**0.0092**
7 to 8 point Facilities	**At 4.0%**	**0.1379**	**0.0055**
9 to 10 point Facilities	**At 5.0%**	**0.0276**	**0.0014**
		1.0000	**0.0237**
			2.25%

		1/01/2010 Rate	4/01/2010 Rate
UPL Available	(current average rate)	$ 129.18	$ 125.75
Base	(Rate in effect at 06-30-05)	$ 103.20	$ 103.20
Balance for Pools and Tiered		$ 25.98	$ 22.55

0.0325	Available funds decrease
0.02655	Factor for Rate Decrease w/ spend down
$ 125.75	New average Rate at 4/1/10 with spenddown adj

X = Pool Amount

$25.98 = X + ($ 103.20 + .3X)*.0225
or $ 25.98 = X + 2.322 + .00675X
or $ 23.658 = 1.00675X
or X = $23.658/1.00675
or X = $ 23.50

Tiered Estimate = $25.98 less $23.50	equals	$ 2.48
Thirty Percent of $ 23.50 = Other Component	equals	$ 7.05
Seventy Percent of $ 23.39= Direct Care	equals	$ 16.45
Total		$ 25.98
Bonus Point =($103.20 +7.05) times.01	equals	$ 1.10

Estimated Days for Regular NF	4,935,283
Base Rate Amount	$ 509,321,190
Other Amount	$ 34,793,744
Subtotal Of Base and Other	$ 544,114,934
Incentive Point Amount	$ 12,239,501
Direct Care Cost Amount	$ 81,185,403
Grand Total Budget	$ 637,539,838
Per Day	$ 129.18
Pool Amount (Direct Care plus Other)	$ 115,979,147

$22.55 = X + ($103.20 + .3X)*.0225
or $22.55 = X + 2.32716 + .00675X
or $20.24934 = 1.00675X
or X = $20.24934/1.00675
or X = $20.11

Tiered Estimate = $22.55 less $20.11	equals	$ 2.44
Thirty Percent of $ 20.11 = Other Component	equals	$ 6.03
Seventy Percent of $ 20.11= Direct Care	equals	$ 14.08
Total		$ 22.55
Bonus Point =($103.20 + 6.03) times.01	equals	$ 1.09

Estimated Days for Regular NF	4,935,283
Base Rate Amount	$ 509,321,206
Other Amount	$ 29,759,756
Subtotal Of Base and Other	$ 539,080,962
Incentive Point Amount	$ 12,042,091
Direct Care Cost Amount	$ 69,488,785
Grand Total Budget	$ 620,611,837
Per Day	$ 125.75
Pool Amount (Direct Care plus Other)	$ 99,248,541
Total Budget Difference	**$ 16,928,001**
State Share 35.57%	**$ 6,021,290**

Presentation to State Plan Amendment Reimbursement Committee
Proposed Reimbursement for Regular ICF's/ MR, Acute Care (16 bed or less)
ICF's/ MR, Aids Nursing Facility and Ventilator Add-on Rates

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for Regular ICF's/MR, Acute Care ICF's/MR, Aids Nursing Facilities and Ventilator Add on Rates. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following methodology change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined in the proposed methodology section.

- ICF/MR, Acute Care ICF/MR and Aids Facility rates were established under the Quality of Care legislation and updated by inflation on several dates.
- The Ventilator patient rate is an add-on to the regular rate for the servicing facility and is based on the additional costs. These costs represent the additional tasks associated with caregivers needed for this type of patient. This add-on has been updated on occasion for inflation, also.

PROPOSED METHODOLOGY

- For all rates above a reduction of 3.25% is necessary to comply with the OHCA Board's directive to the OHCA to meet their responsibility under Article 10, Section 23 of the Oklahoma Constitution.

- For the different facility types the OHCA staff recommends the following rate adjustments:

    1. The rate for regular ICF/MR facilities should be set at $116.97 PPD. This is a change of $3.38 PPD, or 2.81% from the current rate of $120.35.
    2. The rate for Acute Care (16 beds or less) ICF/MR facilities should be set at $150.93 PPD. This is a change of $4.56 PPD, or 2.93% from the current rate of $155.49 PPD.
    3. The rate for Aids Patients in Nursing facilities should be set at set at $177.93 PPD. This is a change of $5.37 PPD, or 2.93% from the current rate of $183.30 PPD.
    4. The Ventilator add-on rate should be set at $135.43 PPD. This is a change of $4.55 PPD, or 3.25% from the current rate add-on of $139.98.

Access to services should not be disrupted because at the current time there is occupancy still available in existing facilities and the number of recipients has not changed dramatically in the last several years.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $1,933,380; $687,703 in state share. The overall rate changes were made after adjusting for any patient spend-down amounts that do not change at this time.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

OKLAHOMA HEALTH CARE AUTHORITY
Rate Adjustment Worksheet
Regular ICF/MR, Acute Care (16 bed or less) ICF/MR, Aids and Ventilator Add-on

Line		Regular ICF/MR Facilities	Acute-Care ICF/MR Facilities	Aids Nursing Facilities	Ventilator Facility Days	Regular Nursing Facilities
1	Current Projected Annual Days	231,127	232,710	10,934	6,980	4,935,283
2	Current Rate	$ 120.35	$ 155.49	$ 183.30	$ 139.98	$ 129.18
3	Average Percent of Patient Spend-down	13.53%	9.76%	9.86%	NA	19.18%^
4	Spend-down Amount in Rate	$ 16.28	$ 15.18	$ 18.07	NA	$ 24.78
5	Net Rate for Medicaid Funding	104.07	140.31	165.23	139.98	$ 104.40
6	3.25% Shortage	$ (3.38)	$ (4.56)	$ (5.37)	$ (4.55)	$ (3.39)
7	Actual Percent of Total Rate	-2.81%	-2.93%	-2.93%	-3.25%	-2.65%
8	Net Medicaid at new levels	$ 100.69	$ 135.75	$ 159.86	$ 135.43	$ 101.01
9	Net Proposed Rate	$ 116.97	$ 150.93	$ 177.93	$ 135.43	$ 125.75
10	Reduction to Program Expenditures	$ (781,735)	$ (1,061,175)	$ (58,715)	$ (31,754)	
	Total Reduction				$ (1,933,380)	
	State Share				(687,703)	

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Dentists

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for the Dental and Orthodontic services. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following methodology change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

PROPOSED METHODOLOGY

Fee schedule rates were last updated July 1, 2009.

There is no Medicare fee schedule comparison for dentists; OHCA uses the American Dental Association (ADA) current dental terminology (CDT) value units. A 2001 Dental fee schedule study ranked Oklahoma 5th nationally in dental fees; (See Exhibit A); a more recent study on select dental fees by state indicated that Oklahoma fees are above national average for Medicaid, although they likely lag behind commercial rates.

	DO120 Periodic Oral Evaluation		**D0272 Bitewings, Two Films**		**D1120 Child Prophylaxis**	
	Fee	As % of National Average	Fee	As % of National Average	Fee	As % of National Average
UNITED STATES	$22.74	100%	$15.64	100%	$31.12	100%
Oklahoma	$23.50	103%	$20.14	129%	$33.57	108%

	D2150 Amalgam, Two Surfaces, Permanent		D7140 Extraction, Erupted Tooth or Exposed Root		D2751 Crown, Porcelain Fused to Metal Base	
	Fee	As % of National Average	Fee	As % of National Average	Fee	As % of National Average
UNITED STATES	$63.34	100%	$53.72	100%	$420.43	100%
Oklahoma	$73.85	117%	$73.86	129%	$537.12	128%

Source: Urban Institute 2008 Medicaid Physician Survey

AGENCY RECOMMENDATION: 3.25% reduction in dental fees. We do not believe that this change will impact access or quality of care.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $5,231,408; $1,860,812 state share.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Exhibit A: Aggregation of Fee Rankings, Various Dental Services

State	Volume-Weighted Ranking, Straight Fees*	Volume-Weighted Ranking, Geographically Adjusted Fees*
Alabama	8	7
Alaska	1	1
Arizona	4	5
Arkansas	24	18
California	**21**	**27**
Colorado	9	12
Connecticut	44	44
Delaware	NA	NA
District of Columbia	45	45
Florida	37	38
Georgia	NA	NA
Hawaii	43	43
Idaho	16	14
Illinois	29	30
Indiana	42	41
Iowa	14	10
Kansas	20	17
Kentucky	25	21
Louisiana	30	31
Maine	NA	NA
Maryland	28	28
Massachusetts	10	20
Michigan	41	42
Minnesota	35	34
Mississippi	NA	NA
Missouri	40	39
Montana	31	29
Nebraska	19	15
Nevada	2	4
New Hampshire	22	24
New Jersey	38	40
New Mexico	6	6
New York	18	25
North Carolina	11	11
North Dakota	15	9
Ohio	17	19
Oklahoma	5	3
Oregon	26	23
Pennsylvania	23	22
Rhode Island	33	36
South Carolina	3	2
South Dakota	34	32
Tennessee	NA	NA
Texas	36	35
Utah	39	37
Vermont	7	8
Virginia	12	16
Washington	27	26
West Virginia	NA	NA
Wisconsin	32	33
Wyoming	13	13

*Note: Rankings apply only to those states where fees were available. 45 states were included in the weighted average.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Rehabilitative Services and Targeted Case Management

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for the rehabilitative services and targeted case management. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

REVIEW OF RATES

Rehabilitative Services

Medicaid rehabilitation includes a full range of treatments that licensed health practitioners may recommend to reduce physical or mental disability or restore eligible beneficiaries to their best possible functional levels. For purposes of this rate review, rehabilitative services are SoonerCare mental health and substance abuse treatment services. Rehabilitation services are delivered in a variety of settings, by a range of practitioners, and through diverse treatment models. For example, rehabilitation services are furnished in freestanding outpatient clinics, the offices of qualified independent practitioners, mobile crisis vehicles, and appropriate community settings, as defined by OHCA. The SoonerCare program covers rehabilitation treatments provided by physicians, nurses, social workers, case managers, behavioral health rehabilitation specialists, aides, licensed counselors, and other health professionals. The non-federal share of services may be funded by state appropriations by several different agencies.

Under Medicare, payment rates for physician services is made at 100% of the physician fee schedule. By Federal law, payments to non-physician practitioners are linked to the physician fee schedule and are paid a percentage differential for services. For example licensed clinical social workers are paid at 75 percent of the fee schedule.[3]

Since rehabilitative services are provided by a range of practitioners, in order to demonstrate that the rates are efficient and economic, rates vary from the Medicare rate based on the difference in the qualifications of the professionals. For example, the current rate (based on a unit of 15 minutes) for psychotherapy by a master's level licensed behavioral health professional is about 71% of the 2009 Medicare schedule.[4] Rates by bachelor's level professionals are paid a percentage of the master's professional rate.

Targeted Case Management Services (TCM)

Case management consists of services that assist eligible beneficiaries in securing medical and other health services necessary to appropriate care and treatment. Case management is not the direct provision of care and services, but instead is a separate and reimbursable class of services under Medicaid that for specific beneficiaries, identifies necessary services, assists in locating the services, identifies providers, and monitors the provision of care. The non- federal share of services to targeted groups are also funded by other agencies such as DHS. OJA and ODMHSAS and OSDH. Rates were calculated based on salaries and wages, administrative and overhead costs and a minimum of 50% productivity.

Rates for rehabilitative and case management services were last updated April 1, 2009. [5]

AGENCY RECOMMENDATION: A 3.25% reduction to the current fee schedule rates for rehabilitative and targeted case management services provided by outpatient behavioral health agencies and organizations. (This reduction does not include those services and or delivery models of care solely funded by other state agencies). This reduction includes TCM. We do not believe that this change will negatively impact access to services.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $4,436,307; $1,577,994 state share.

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[3] However, technically, Medicare's liability for psychotherapy is limited to 50 percent (62.5 percent of 80 percent of the approved amount) for covered expenses incurred per calendar year. This means that the beneficiary has a greater co-pay amount for mental health than physical health (80 percent). This disparity is being phased out over a 5 year period beginning in 2010.

[4]. Rates were originally set based on 2007 Medicare. In 2009, Medicare boosted the rates for selected psychotherapy codes, which caused the lower ratio of the SoonerCare rates to the 2009 fee schedule.

[5] Switched from CPT session codes to 15 minute units for psychotherapy

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Durable Medical Equipment (DME)

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for Durable Medical Equipment services. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following methodology change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area

REVIEW OF CURRENT RATES

Current Durable Medical Equipment rates which also include Prosthetics, Orthotics, Supplies, eyeglasses, and hearing aids have rates that have been established by the agency in accordance with the proposed State Plan. Established rates are either at 100% of the Medicare allowable or a percentage of the Medicare allowable.

AGENCY RECOMMENDATION

Update the DME rates to reflect the reduction of 3.25% on established rates. We believe this change will not affect access to DMEPOS services.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $1,655,167; $588,743 state share.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rate of the
Pharmacy Dispensing Fee

ISSUE

The Oklahoma Health Care Authority (OHCA) recommends a revision to the current dispensing fee paid to pharmacy providers. The OHCA is proposing recalculation of the current rates by a reduction of 3.25%.

BACKGROUND

The OHCA pays pharmacies using a formula of ingredient cost plus dispensing fee. This change applies only to the dispensing fee portion of the payment.

The OHCA Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following methodology change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area

UPDATES TO REIMBURSEMENT RATES

The dispensing fee amount has not been changed since 1995. At that time, it was reduced from $5.10 per prescription to $4.15 per prescription. This proposal would reduce the dispensing fee to $4.02 per prescription.

Determination of Proposed Rate

A survey of the dispensing fees paid by Medicaid programs in surrounding states revealed that Oklahoma's dispensing fee of $4.15 is slightly higher than the median of $4.12. The range of dispensing fees starts at $3.40 in Kansas and is $7.50 in Texas. Oklahoma's dispensing fee would move from the fourth highest at $4.15 to the fifth highest at $4.02.

States included in the survey, along with their dispensing fees are Kansas, $3.40; New Mexico, $3.65; Colorado $4.00; Missouri $4.09; Arkansas, $5.51; Louisiana, $5.77; and Texas, $7.50.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $693,967; $246,844 state share.

EFFECTIVE DATE

The effective date of this change in rate is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Methodology
Injectable Drugs Dispensed through the Vendor Drug Program

ISSUE

The Oklahoma Health Care Authority (OHCA), Pharmacy Division recommends a revision to the current rates and reimbursement structure for injectable drugs which are dispensed through the Vendor Drug Program. The OHCA is proposing this new pricing methodology to equalize payment for these medications whether they are billed using the HCPCS codes in the medical program or through the Vendor Drug Program using an NDC code. The proposed reimbursement rate is equivalent to the Medicare Part B rate.

BACKGROUND

The OHCA changed reimbursement for physician administered drugs beginning January 1, 2010 to be equal to the Medicare Part B pricing of Average Sales Price (ASP) plus 6%. These same drugs, when reimbursed through a pharmacy claim, are paid at Average Wholesale Price (AWP) minus 12%.

The OHCA Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

UPDATES TO REIMBURSEMENT RATES

The current reimbursement for these products has been the same since 2002. Prior to that, these drugs were reimbursed through the pharmacy program at AWP – 10.5% and were priced through a proprietary pricing structure from a vendor if purchased through physician claims.

Determination of Proposed Rate
The proposed rate is the prevailing Medicare rate for these drug products. When dispensed through a pharmacy, the provider will be reimbursed at a rate which is equivalent to the Medicare rate plus the standard pharmacy dispensing fee.

ADEQUACY OF PAYMENT RATES

Providers may provide invoice documentation to support a reconsideration of individual product rates.

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $2,600,000; $924,820 state share. This accounts for lost revenue from drug rebate.

EFFECTIVE DATE

The proposed effective date for this change is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Methodology
State Maximum Allowable Cost for Vendor Drug Program

ISSUE

The Oklahoma Health Care Authority (OHCA), Pharmacy Division recommends a revision to the current rates and reimbursement structure for multiple source drugs. The OHCA is proposing this new pricing methodology to maximize savings for the Vendor Drug Program.

BACKGROUND

OHCA implemented a State Maximum Allowable Cost (SMAC) program to determine the reimbursement level for multiple source products in 2000. Multiple source products are those which are marketed or sold by two or more manufacturers or which are sold by a single manufacturer under multiple names. In 2002, the SMAC methodology was changed slightly. Since that time, many states have opted to utilize market-based SMAC pricing under a formula developed by a contracted vendor. This is the solution proposed by OHCA at this time.

UPDATES TO REIMBURSEMENT RATES

The current methodology for multiple source products has been the same since 2002.

Determination of Proposed Rate

The proposed rate would be determined by a formula from a contracted vendor based on market prices for multiple source products available through wholesalers doing business with Oklahoma pharmacies.

By using market-based pricing from available products, the agency is protected from inflated published pricing benchmarks and pharmacies are protected because the products must be available within the state to be used as a basis for reimbursement.

ADEQUACY OF PAYMENT RATES

Section 1902 (a)(30)(A) of the Social Security Act ("the Act") requires that state payment rates are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available to the extent that such care and services are available to the general population in the geographic area. We believe this change is consistent with this requirement.

Pharmacy providers are encouraged to notify the agency when a product is not available for the SMAC rate. They then may supply the agency with a current invoice showing the best available price and the pricing is re-evaluated and corrected.

BUDGET IMPACT

This proposed change is estimated to be budget neutral.

EFFECTIVE DATE

The effective date of these changes is April 1, 2010.

Presentation to State Plan Amendment Reimbursement Committee
Updates to Payment Rates
Inpatient Psychiatric Services for Individuals Under Age 21
and Community-Based Alternatives

ISSUE

The Oklahoma Health Care Authority (OHCA), Finance Division recommends a revision to the current rates and reimbursement structure for residential treatment provided by psychiatric units of general medical/surgical hospitals, psychiatric hospitals and psychiatric residential treatment facilities (PRTFs). The OHCA is proposing recalculation of the current per diems along with a tiered reimbursement methodology that declines based on length of stay. These changes are being made in order to encourage discharge to more appropriate community alternatives than residential placement.

BACKGROUND

Beginning October 2005, the OHCA implemented all-inclusive payment rates for residential psychiatric services based on facility and patient characteristics (peer groups). In addition to room and board, the rates include professional and prescription drugs as well as any other medical required during the inpatient stay. This rate change was the result of an audit by the Centers for Medicare and Medicaid Services (CMS) of services paid outside the per diem rate, while a child was an inpatient in an Institution for Mental Diseases (IMD)[1]. Rates were last updated effective January 1, 2008. Current rates vary based on facility and patient characteristics and range from $330 to $413 per day for in-state providers. The average length of stay is 70 days.

According to a September 2009 report by Mathematica Policy Research, Inc., "the primary source of behavioral health expenditure growth in Oklahoma in recent years has been Psychiatric Residential Treatment Facility (PRTFs) services for children. Expenditures for these PRTFs have grown from $58 million in SFY06 to $112 million in SFY09, and now account for over 45 percent of all Medicaid behavioral health expenditures for children." The report further stated that "while a very small number of children may require mental health services in PRTFs when there is an immediate need that cannot be met in a less restrictive setting, there is now a consensus among providers, researchers, and family advocates that stays in PRTFs should be short-term with the goal of family preservation and timely integration back into the community. There is little evidence that stays in PRTFs result in long-term gains in functioning"[2]

Mathematica recommended that OHCA revise PRTF reimbursement in ways that would both contain costs and improve performance, including reducing the per diem rate for longer lengths of stay. Linking reimbursement levels more closely to actual service needs would increase PRTF incentives to participate actively in discharge planning.

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[1] CMS cited Public Law 100-360 of 1988 which defines an IMD as a hospital or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. If the institution is licensed as a psychiatric facility, CMS considers the institution an IMD. The audit determined that OHCA should not claim Federal Financial Participation (FFP) for services paid outside the per diem.

[2] SoonerCare Behavioral Health Expenditure Recommendations, Mathematica Policy Research, September 2009,

Eligible Providers of Inpatient Psychiatric Services and Staffing

Federal regulations at 42 CFR 440.160 specify that inpatient psychiatric services are provided by:

> 1) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or
>
> (2) A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.

In addition to the above requirements, residential services that are provided by a medical/surgical unit of a hospital must meet licensure requirements for hospitals specified by the state, which requires RN staffing 24 hours per day. OHCA rules require other programs to be licensed by the Oklahoma Department of Human Services as a residential child placing agency - the minimum staffing ratio is 1:6 during waking hours. OHCA rules require higher staffing ratios of 1:3 for neurodevelopmental disorder programs.

UPDATES TO PER DIEM RATES

The current rates for residential services are peer grouped as follows: specialty unit per diem for neurodevelopmental disorder programs, hospital-based programs, freestanding/standard programs, community-based extended and community based transitional. We are proposing to recalculate the current rates, implementing a 3.25% reduction due to the increased volume since 2006, with the following methodology: **1)** a standard rate for staff secure residential programs that meets the minimum staffing and resources for child placing agency licensure - with a tiered approach that declines after the first 45 days; **2)** a facility differential due to the higher intensity staffing required by physically secure/locked facilities and to further recognize the higher costs inherent in hospital based programs (RN staffing and overhead allocations for services such as dedicated emergency departments) with rates that also declines after 45 days; **3)** a new peer group payment for sexual offender programs (these programs require separate units from the general population for treatment); **4)** and new per diem rates for eating disorder programs (we are unable to contract with any instate providers for this service). This will allow for a short-term extended stay for the resident until ready for outpatient programs. To encourage proactive discharge planning, we recommend that the rates be reduced for days 46-90 by 10% and for days 91+ by an additional 5% for **the standard and restrictive/secure programs**.

Behavior and developmental disorder programs generally have higher costs due to the required higher staffing ratios and costs of prescription drugs and other medical services, and generally are longer term residential programs. No additional reduction in the rates is recommended after this change in the current base rates for specialty units and sexual offender programs.

Determination of Proposed Base Rates

The proposed rates for all residential programs are calculated based on a standard overall reduction of 3.25% to the current base rates. We reviewed rates paid by other states, cost report data, surveys and other relevant factors, and recommend the following base rates:

Peer Group/	Licensure Standard	New Base Rates	Current Rates	%Chg
Standard (default)	Child Placing	**$319.54**	$330.27	-3.25%
Restrictive / Secure	Child Placing	**$336.57**	$347.88	-3.25%
Restrictive / Secure	Hospital	**$345.05**	$356.64	-3.25%
Sexual Offender	Child Placing	**$336.57**	$347.88	-3.25%
Sexual Offender	Hospital	**$345.05**	$356.64	-3.25%
Neurodevelopmental	Child Placing	**$400.05**	$413.49	-3.25%
EatingDisorders/TBI	Hospital	**$432.26**	None	100%

ALTERNATIVE SERIVICES

PRTFs with 16 beds or fewer
We are also proposing an increase to the current rate for services defined as "community-based transitional" (CBT) programs, due to a market survey that indicates that the current rate of $190.97 per day is not sufficient to enlist enough providers. The CBT offers a more family like program in a less restrictive environment. In addition to the per diem, separate payment may be made for professional and ancillary services, as these facilities are not IMDs. The proposed per diem is **$220** per day.

Partial Hospitalization
The number of children accessing residential treatment has increased from 3,425 in SFY06 to 4,180 in SFY09. Partial Hospitalization is a short-term, structured outpatient day program that is highly intensive but does not require 24 hour service. The addition of partial hospitalization day program services will allow for an appropriate continuum on an outpatient basis. The recommended hourly rate of $42.80 is based on the Medicare per diem method for a maximum of 4 units of service per day. The proposed effective date is based on available funding.

The actual changes we are proposing are shown in Attachment A.

ADEQUACY OF PAYMENT RATES

Section 1902 (a)(30)(A) of the Social Security Act ("the Act") requires that state payment rates are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available to the extent that such care and services are available to the general population in the geographic area. We believe these changes are consistent with this requirement,

BUDGET IMPACT

The estimated annual change is a decrease in the amount of $7,783,187 million; $2,768,480 million state share.

EFFECTIVE DATE

The effective date of these changes in residential rates is April 1, 2010.

Attachment A

Service	Unit	Hospital Rate	Non-Hospital Rate
Residential Treatment: Non-Secure			***$ 330.27***
Days 1-45	Per Diem		**$ 319.54**
Days 46-90	Per Diem		**$ 287.58**
Days 91 +	Per Diem		**$ 273.20**
Includes residential TBI & Speicalty stepdown programs. Rates are all-inclusive			
Residential Treatment : Restrictive/Secure		***$ 356.64***	***$ 347.88***
Days 1-45	Per Diem	**$ 345.05**	**$ 336.57**
Days 46-90	Per Diem	**$ 310.54**	**$ 302.92**
Days 91 +	Per Diem	**$ 295.02**	**$ 287.77**
Rates are all-inclusive			
Specialty: Sexual Offender		***$ 356.64***	***$ 347.88***
Days 1-45	Per Diem	**$ 345.05**	**$ 336.57**
Days 46-90	Per Diem	**$ 345.05**	**$ 336.57**
Days 91 +	Per Diem	**$ 345.05**	**$ 336.57**
Rates are all-inclusive			
Other Specialty		***$ -***	***$ 413.49***
Days 1-45	Per Diem	**$ 432.26**	**$ 400.05**
Days 46-90	Per Diem		**$ 400.05**
Days 91 +	Per Diem		**$ 400.05**
Hospital specialty includes: neuropsychiatric dx, Eating disorders and TBI. Non-hospital specialty programs include RAD; ASD; MR/MI. Rates are all-inclusive			
Residential Treatment (16 beds or less)		***$ 190.97***	***$ 190.97***
Transitional (CBT) MH	Per Diem	**$ 220.49**	**$ 220.49**
Partial Hospitalization			
Max 4 units per day	Per Hour	**$42.80**	

8.b-1 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 83. ~~Residential Behavior Management Services in Foster Care Settings~~ Outpatient Behavioral Health Services in Therapeutic Foster Care Homes
317:30-5-740. [AMENDED]
317:30-5-740.1. [AMENDED]
317:30-5-741. [AMENDED]
317:30-5-742. [AMENDED]
317:30-5-742.1. [AMENDED]
317:30-5-742.2. [AMENDED]
317:30-5-743. [REVOKED]
317:30-5-743.1. [AMENDED]
317:30-5-744. [AMENDED]
317:30-5-745. {AMENDED]
(Reference APA WF # 10-02)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to amend policy to change the reimbursement methodology for outpatient behavioral health services in Therapeutic Foster Care settings to comply with directives from the Centers for Medicare and Medicaid Services (CMS).

ANALYSIS: Rules are revised to change the reimbursement methodology for outpatient behavioral health services provided in Therapeutic Foster Care settings from an all inclusive per diem payment to fee-for-service. The requirement of "unbundling" per diem rates has been an ongoing trend for the Centers for Medicare and Medicaid Services (CMS). This change will more closely align our reimbursement with CMS preferences and requirements. Rules are also revised to update terminology, provider requirements and coverage guidelines.

BUDGET IMPACT: Agency staff has determined that the estimated cost to OHCA for the remainder of SFY10 is $456,372. However, the Agency expects to realize a savings beginning next fiscal year by diverting members from more costly inpatient stays by giving them access to community based alternatives.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 21, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor’s approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Outpatient behavioral health rules are revised to change the reimbursement methodology for services provided in Therapeutic Foster

Care settings from an all inclusive per diem payment to fee-for-service.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 83. ~~RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS~~ OUTPATIENT BEHAVIORAL HEALTH SERVICES IN THERAPEUTIC FOSTER CARE HOMES

317:30-5-740. Eligible providers

~~(a) Eligible Residential Behavior Management Service (RBMS) agencies must:~~

~~(1) have a current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency, and~~

~~(2) have a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, and~~

~~(3) have a contract with the Oklahoma Health Care Authority.~~

~~(b) Effective July 1, 2002, an eligible RBMS must:~~

~~(1) have a current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency, and~~

~~(2) have a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, and~~

~~(3) have a contract with the Oklahoma Health Care Authority, and~~

~~(4) have current accreditation status appropriate to provide behavioral management services in a foster care setting from:~~

~~(A) Joint Commission on Accreditation of Health Care Organization (JCAHO), or~~

~~(B) the Rehabilitation Accreditation Commission (CARF), or~~

~~(C) the Council on Accreditation (COA), or~~

~~(D) the American Osteopathic Association (AOA).~~

~~(c) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers for behavior management therapies in a foster care setting, providers must have the following qualifications:~~

~~(1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor, or under Board approved supervision to be licensed in one of the above stated areas; or~~

~~(2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided AND~~

~~(3) demonstrate a general professional or educational background in the following areas:~~

~~(A) case management, assessment and treatment planning;~~

~~(B) treatment of victims of physical, emotional, and sexual abuse;~~

~~(C) treatment of children with attachment disorders;~~

~~(D) treatment of children with hyperactivity or attention deficit disorders;~~

~~(E) treatment methodologies for emotionally disturbed children and youth;~~

~~(F) normal childhood development and the effect of abuse and/or neglect on childhood development;~~

~~(G) treatment of children and families with substance abuse and chemical dependency disorders;~~

~~(H) anger management;~~

~~(I) crisis intervention; and~~

~~(J) trauma informed methodology.~~

~~(d) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for Group Rehabilitative Treatment Services in a foster care setting facilitated by their staff, providers must have the following qualifications:~~

~~(1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, alcohol and drug counselor, or behavioral practitioner, or under Board approved supervision to be licensed in one of the above stated areas; or~~

~~(2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided; or~~

~~(3) have a baccalaureate degree in a behavioral health field, a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and have access to weekly consultation with a licensed mental health professional.~~

~~(e) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for Individual Rehabilitative Treatment Services for redevelopment therapy in a foster care setting facilitated by their staff, providers must have the following qualifications:~~

~~(1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, alcohol and drug counselor, or behavioral practitioner, or under Board approved supervision to be licensed in one of the above stated areas; or~~

~~(2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided; or~~

~~(3) have a baccalaureate degree in a behavioral health field, a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and have access to weekly consultation with a licensed mental health professional; or~~

~~(4) be classified by the RBMS agency as a Treatment Parent Specialist under the supervision of a licensed, or under-supervision for licensure, behavioral health professional of the RBMS.~~

~~(A) The Treatment Parent Specialist must meet the following criteria:~~

~~(i) have a high school diploma or equivalent;~~

~~(ii) be employed by the RBMS as a foster parent complete with OSBI and OKDHS background screening;~~

~~(iii) completion of therapeutic foster parent training outlined in 317:30-5-740.1(a);~~

~~(iv) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, professional;~~

~~(v) have weekly contact with the RBMS professional staff; and~~

~~(vi) complete required annual trainings.~~

(a) **Definitions**. The following words or terms used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

(1) **Therapeutic foster care (TFC) agencies**.A foster care agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Therapeutic foster care settings are foster family homes.

(2) **Therapeutic foster care homes**. Agency-supervised private family homes in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family living environment for children and adolescents with significant emotional or behavioral problems who require a higher level of care than is found in a conventional foster home but do not require placement in a more restrictive setting. Therapeutic foster care homes are considered the least restrictive out-of-home placement for children with severe emotional disorders.

(b) **TFC Agency Requirements.** Eligible TFC agencies must have:

(1) current certification from the Oklahoma Department of Human services (OKDHS) as a child placing agency;

(2) a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, or OJA;

(3) a contract with the Oklahoma Health Care Authority; and

(4) a current accreditation status appropriate to provide outpatient behavioral health services in a foster care setting from:

(A) The Joint Commission formerly the Joint Commission on Accreditation (JCAHO), or

(B) the Rehabilitation Accreditation Commission (CARF), or

(C) the Council on Accreditation (COA), or

(D) the American Osteopathic Association (AOA).

317:30-5-740.1. ~~Eligible provider contracting requirements~~ Provider qualifications and requirements

~~(a) Eligible agency providers that are defined in section OAC 317:30-5-740 shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:~~

~~(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;~~

~~(2) treatment of victims of physical, emotional, and sexual abuse;~~

~~(3) treatment of children with attachment disorders;~~

~~(4) treatment of children with hyperactive or attention deficit disorders;~~

~~(5) normal childhood development and the effect of abuse and/or neglect on childhood development;~~

~~(6) treatment of children and families with substance abuse and chemical dependency disorders;~~

~~(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;~~

~~(8) anger management;~~

~~(9) inpatient authorization procedures;~~

~~(10) crisis intervention;~~

~~(11) grief and loss issues for children in foster care;~~

~~(12) the significance/value of birth families to children receiving services in residential behavior management services in a foster care setting; and~~

~~(13) trauma informed methodology.~~

~~(b) Eligible agency providers defined at OAC 317:30-5-740 must provide staff with access to professional psychiatric and/or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment.~~

(a) **Therapeutic foster care model**. Children in the TFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited; no more than two TFC children in a home at any one time unless

additional cases are specifically authorized by OKDHS, Division of Children and Family Services or OJA.

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the child's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the child, the child's parents, others closely involved with the child and family. It also includes the following:

(1) **Behavioral Health Rehabilitation Specialist (BHRS)** A bachelors level team member that may provider support services and case management. In addition to the minimum requirements at OAC 317:30-5-240.3 (c), the BHRS must have:

(A) a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and

(B) have access to weekly consultation with a licensed behavioral health professional.

(2) **Licensed Behavioral Health Professional (LBHP)**. A masters level professional that provides treatment and supervision for the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a), the LBHP in a TFC setting must demonstrate a general processional or educational background in the following areas:

(A) case management, assessment and treatment planning;

(B) treatment of victims of physical, emotional, and sexual abuse;

(C) treatment of children with attachment disorders;

(D) treatment of children with hyperactivity or attention deficit disorders;

(E) treatment methodologies for emotionally disturbed children and youth;

(F) normal childhood development and the effect of abuse and/or neglect on childhood development;

(G) anger management;

(H) crisis intervention; and

(I) trauma informed methodology.

(3) **Licensed Psychiatrist and/or psychologist**. TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment. See OAC 317:30-5-240.3(a) and OAC 317:25-275.

(4) **Treatment Parent Specialist (TPS)**. The TPS serve as integral members of the team of professionals providing services for the child. The TPS receives special training in mental health issues, behavior management and parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. They provide services for the child, get the child to therapy and other treatment appointments, write daily notes about interventions and attend treatment team meetings. The TPS must be under the supervision of a licensed behavioral health professional of the foster care agency and meet the following criteria:

(A) have a high school diploma or equivalent;

(B) be employed by the foster care agency as a foster parent complete with OSBI and OKDHS background screening;

(C) completion of therapeutic foster parent training outlined in this section;

(D) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the child’s family therapy;

(E) have weekly contact with the foster care agency professional staff; and
(F) complete required annual trainings.

(c) **Agency assurances.** The TFC agency must ensure that each individual that renders treatment services (whether employed by or contracted by the agency) meets the minimum provider qualifications for the service. Individuals eligible for direct enrollment must have a contract on file with the Oklahoma Health Care Authority

(d) **Policies and Procedures.** Eligible TFC agency providers that are defined in section OAC 317:30-5-740(a) shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;
(2) treatment of victims of physical, emotional, and sexual abuse;
(3) treatment of children with attachment disorders;
(4) treatment of children with hyperactive or attention deficit disorders;
(5) normal childhood development and the effect of abuse and/or neglect on childhood development;
(6) treatment of children and families with substance abuse and chemical dependency disorders;
(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;
(8) anger management;
(9) inpatient authorization procedures;
(10) crisis intervention;
(11) grief and loss issues for children in foster care;
(12) the significance/value of birth families to children receiving outpatient behavioral health services in a foster care setting; and
(13) trauma informed methodology.

317:30-5-741. Coverage by category

(a) **Adults.** ~~Residential Behavior Management~~ Outpatient Behavioral Health Services in Therapeutic Foster settings are not covered for adults.

(b) **Children.** ~~Residential Behavior Management~~ Outpatient behavioral health ~~Services~~ services are ~~provided in residential foster care programs~~ authorized in therapeutic foster care settings for certain children and youth ~~authorized~~ by the designated agent of the Oklahoma Health Care Authority. The children and youth authorized ~~designated~~ for services in this ~~program~~ setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this ~~program~~ setting. The medical necessity criteria are continually met for initial requests for services and all subsequent requests for services/ extensions. Medical necessity criteria ~~are as follows:~~ is delineated in the OHCA Behavioral Health Provider Manual.

~~(1) Any DSM-IV AXIS I primary diagnosis, with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Mental Health Professional as defined in OAC 317:30-5-240(c) within the 30 day period resulting in a DSM-IV AXIS I primary diagnosis with the exception of V codes and adjustments disorders, with a detailed~~

~~description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.~~

~~(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.~~

~~(3) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.~~

~~(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.~~

~~(5) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.~~

~~(6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.~~

317:30-5-742. Description of services

~~(a) Behavior management services mean all the services listed in (1)-(8) of this subsection as provided in the individual plan of care. Each of the service requirements has special duration and frequency requirements as set out in OAC 317:30-5-742.2.~~

~~(1) Individual therapy;~~

~~(2) Substance abuse/chemical dependency education, prevention, and therapy;~~

~~(3) Group rehabilitative treatment;~~

~~(4) Family therapy;~~

~~(5) Basic living skills redevelopment;~~

~~(6) Social skills redevelopment;~~

~~(7) Crisis/behavior management redirection; and~~

~~(8) Discharge planning.~~

~~(b) Behavior management services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. Behavior management services are considered an ancillary component of inpatient hospital care and residential treatment services provided in a less restrictive setting and as a less costly alternative to inpatient psychiatric hospital services and other residential treatment services.~~

~~(c) Behavioral Management Services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(1).~~

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting.

(b) Outpatient behavioral health services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(b)(1). Treatment services in a therapeutic foster care setting may include an array of services listed in (1) – (6) of this subsection as provided in the individual plan of care. Services include, but may not be limited to:

(1) Individual, family and group therapy;

(2) Substance abuse/chemical dependency education, prevention, and therapy;

(3) Psychosocial rehabilitation and support services;
(4) Behavior management
(5) Crisis intervention; and
(6) Case Management.

317:30-5-742.1. ~~Residential behavior management reimbursement~~ Reimbursement

~~(a) All Residential Behavioral Management Services must be prior authorized by the designated agent of the Oklahoma Health Care Authority before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized.~~

~~(b) The Oklahoma Health Care Authority will not reimburse for the services defined in OAC 317:30-5-742 for more than two children in a home at any one time unless additional cases are specifically authorized by the Oklahoma Department of Human Services, Division of Children and Family Services or Oklahoma Office of Juvenile Affairs.~~

~~(c) A child who is eligible for the services defined in OAC 317:30-5-742 is not to receive any other outpatient behavioral health services defined by OHCA unless prior authorized by OHCA or its designated agent. For example, separate individual therapy for a child eligible for Residential Behavioral Management Services will not generally be authorized because this service is part of the bundled service provided by a Residential Behavioral Management provider. If additional outpatient services are authorized by OHCA or its designated agent, the service provider may not be the provider of the Residential Behavioral Management Services.~~

~~(d) OHCA will not reimburse an eligible service provider for units of service that are not authorized before the service is delivered.~~

~~(e) Initial requests for residential foster care and the first extension request will be approved for a maximum of six months. All subsequent requests for services/extensions will be for a maximum time period not to exceed three months.~~

~~(f) No reimbursement is made for a service for a member without a written individual plan of care for each member as described in OAC 317:30-5-742.2(1). Each individual plan of care must contain all of the services required in OAC 317:30-5-742(a).~~ Services provided to a member without a written individual plan of care as described in OAC 317:30-5-742.2(b)(1) will not be reimbursed.

317:30-5-742.2. ~~Required Residential Behavior Management Services~~ Individual plan of care and prior authorization of services

~~All residential behavior management services in a foster care setting (RBMS) are provided as a result of an individual assessment of the member's needs and documented in the individual plan of care. Services including individual plan of care development, individual therapy, family therapy, basic living skills (re)development, social skills (re)development, group rehabilitative treatment, substance abuse/chemical dependency education, prevention and therapy are provided per minimum requirements identified in this section. All services are based upon the member's individual plan of care and consistent with assessed needs. Individual therapy and family therapy may be provided in lieu of group rehabilitative therapy. Crisis behavior management and redirection services are provided as needed. The following represent the minimum service requirement for a member receiving Residential Behavior Management Services:~~

(a) All outpatient behavioral health services must be prior authorized by the designated agent of the Oklahoma Health Care Authority before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized.

(b) All outpatient behavioral health services in a foster care setting are provided as a result of an individual assessment of the members needs and documented in the individual plan of care.

(1) **Individual plan of care requirement**.

(A) A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within ~~30~~ 14 days of admission with documented input from the member, legal guardian (OKDHS/OJA) staff, the foster parent (when applicable) and the treatment provider(s). It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and have them fax back their signature; however, the provider must obtain the original signature for the clinical file within 30 days. No stamped or ~~Xeroxed~~ photocopied signatures are allowed. This plan must be revised and updated each 90 days with documented involvement of the legal guardian and resident.

(B) The individual plan of care must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented full five-axis DSM-IV diagnosis, appropriate ~~long term and short term~~ goals, and corresponding reasonable and attainable ~~measurable~~ objectives ~~to obtain the stated goals~~ and action steps within the expected time lines. Each member's individual plan of care is to also address the provider agency's plans with regard to the provision of services. ~~in each of the following areas:~~

~~(i) individual therapy;~~

~~(ii) substance abuse/chemical dependency education, prevention, and therapy;~~

~~(iii) group rehabilitative treatment;~~

~~(iv) family therapy;~~

~~(v) basic living skills (re)development;~~

~~(vi) social skills (re)development;~~

~~(vii) crisis/behavior management and redirection; and~~

~~(viii) discharge planning.~~

(C) Requests for outpatient behavioral services in a foster care setting will be approved for a maximum of three months.

~~(2) **Individual therapy.** The provider agency must provide individual therapy on a monthly basis to youth placed in the residential foster care homes. Individual therapy is a method of treating mental health and alcohol and other drug disorders using face to face, one to one interaction between a Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(d) and the member to promote behavioral, emotional or psychological change. Individual therapy is age appropriate and the techniques and modalities employed are relevant to the goals of the individual's plan of care. The required service for each member served is a minimum of four 30 minute sessions per month of individual therapy.~~

~~(3) **Group rehabilitative treatment.** The provider agency will provide group rehabilitative treatment as specified in the individual plan of care for the treatment of mental health and behavioral disorders for a minimum of two 30 minute sessions per month. Group rehabilitative services provided for children receiving RBMS in a foster care setting include educational and supportive services such as basic living skills, social skills (re)development, interdependent living, self-care, lifestyle change and recovery principles. Services are provided in the least restrictive setting appropriate for the reduction of emotional and behavioral~~

~~impairment and suitable to the restoration of the member's functioning. Services are consistent with the requirements of age and appropriate to the member's behavioral functioning and self sufficiency. Meeting with family members, legal guardian, and/or care givers is covered when the services are directed exclusively to the effective treatment of the individual member. Each service provided under this section must have a goal and purpose, which relates directly to the member's individual plan of care. Compensable rehabilitative treatment services are provided to members who have the ability to benefit from the service. The member must be able to actively participate and must possess the cognitive, developmental, and communication skills necessary to benefit from the service. Travel time to and from activities is not covered. Staff to resident ratio shall not exceed eight children to one staff member. Staff appropriately trained, including training and certification in a recognized anger management intervention technique, such as MANDT or Controlling Aggressive Patient Environment (CAPE), must be present in the group. Thirty minutes of individual therapy and/or family therapy may be provided in lieu of one hour of group rehabilitative treatment.~~

~~(4) **Family therapy.** The provider agency must provide family therapy as indicated on the member's individual plan of care. Family therapy is an interaction between a Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(d) and the family member(s) designated on the individual plan of care. The interaction is intended to facilitate behavioral, emotional, or psychological change and promote understanding through successful communication skills. Family therapy must be provided for a minimum of four 30-minute sessions per month. The agency must:~~

~~(A) work with the caretaker to whom the member will be discharged, as identified by the OKDHS/OJA local worker;~~

~~(B) seek to support and enhance the child's relationships with nuclear and appropriate extended family members, if the OKDHS/OJA plan for the child indicates family reunification;~~

~~(C) arrange for and encourage regular contact and visitation between children and their parents and other family members as specified in the individual plan of care;~~

~~(D) seek to involve the child's parents/legal guardian in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program;~~

~~(E) provide consultation to the residential foster care parents;~~

~~(F) provide regular support and technical assistance to residential foster parents in their implementation of the individual plan of care and with regard to other responsibilities they undertake. Fundamental components of such technical assistance will be the design or revision of in-home treatment strategies including proactive goal-setting and planning, and the provision of ongoing child-specific skills training and problem-solving in the home during home visits. Other types of support and supervision must include emotional support and relationship-building, the sharing of information and general training to enhance professional development, assessment of the youth's progress, observation/assessment of family interactions and stress, and assessment of safety issues. Residential foster parents and their biological children must have access to counseling and therapeutic services arranged by the provider agency for personal issues/problems caused or exacerbated by their work as residential foster parents. Such issues may include, for example, marital stress, or abuse of~~

~~their own child(ren) by a child placed in their care by the provider agency.~~

(2) **Description of Services.** Agency services include:

(A) **Individual, family and group therapy**. See OAC 317:30-5-241.2(a),(b), and (c).

~~(5)~~(B) **Substance abuse/chemical dependency ~~education, prevention and~~ therapy.** ~~The provider agency must provide substance~~ Substance abuse/chemical dependency therapy ~~for all members who are identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance abuse and/or chemical dependency. If a member is identified as requiring substance abuse/chemical dependency therapy, the provider agency must provide age appropriate substance abuse/chemical dependency therapy~~ can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance abuse and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. ~~For those members identified above, substance abuse/chemical dependency therapy must be provided a minimum of two one-hour sessions per month. In the case a member who has no identifiable emotional or behavioral problem directly related to substance abuse and/or chemical dependency, members must be provided age appropriate education and prevention activities. These may include self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums. For members who do not need substance and/or chemical dependency therapy, a minimum of two hours of education and/or prevention therapy per three month period is required.~~

(C) **Psychosocial rehabilitation (PSR).**

~~(6)~~ (i) **Basic living skills redevelopment.** ~~The provider agency must provide goal directed activities for each member to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopments are daily activities that are age appropriate and relevant to the goals of the individual plan of care. This may include, but is not limited to, food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, and job application and retention skills. Basic living skill redevelopment therapy must occur a minimum of 30 minutes each day.~~ Daily activities that are age appropriate and relevant to the goals of the individual plan of care. This may include, but is not limited to, food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, and job application and retention skills.

~~(7)~~ (ii) **Social skills redevelopment.** ~~The provider agency must provide goal directed activities for each member to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development curriculums approved by the provider agency. Social skill redevelopment therapy must occur a minimum of two 30-minute activities each day.~~ Goal directed activities for each member to

restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development.

~~(8)~~(iii) **Crisis/behavior management and redirection.** The provider agency must provide crisis/behavior redirection by agency staff as needed 24 hours per day, 7 days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption.

~~(9)~~(iv) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care and outlines plans that are ~~and~~ in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the Oklahoma Department of Human Services or the Office of Juvenile Affairs must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.

317:30-5-743. Payment rates and recoupment [REVOKED]

~~(a) The payment rate for RBMS is a per diem (per day) amount for each child each day. The rate for this service is set by the Rates and Standards Committee of the Oklahoma Health Care Authority.~~

~~(b) In the case a recoupment is sought by the Oklahoma Health Care Authority because it determines that RBMS were not delivered or not delivered as required, a recoupment will be determined by:~~

~~(1) determining the value of the missing program requirements, and~~

~~(2) subtracting the value from the daily rate.~~

317:30-5-743.1. Inspection of Care

There will be an on site Inspection of Care of each Therapeutic Foster Care (TFC) agency that provides care to members which will be performed by the OHCA or its designated agent. The OHCA will designate the members of the Inspection of Care Team. This team will consist of two team members and will be comprised of Licensed Behavioral Health Professionals and/or Registered Nurses. The Inspection may include observation and contact with members. The Inspection of Care (IOC) review will consist of members present or listed as facility residents at the beginning of the Inspection of Care visit as well as members on which claims have been filed with OHCA for TFC services. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the on-site inspection, the Inspection of Care Team will report its findings to the ~~facility~~ agency. The ~~facility~~ agency will be provided with written notification if the findings of the Inspection of Care have resulted in any deficiencies. A copy of the final report will be sent to the ~~facilities'~~ agency's accrediting agency. Deficiencies found during the IOC may result in a ~~partial~~ recoupment ~~or a full recoupment~~ of the compensation received for that service. The

individual plan of care is considered to be critical to the integrity of care and treatment and must be completed within the time lines designated at OAC 317:30-5-742.2. ~~For each day that the individual plan of care is not contained within the member's records, those days will warrant full per-diem recoupment of the compensation received. If the review findings have resulted in a partial per-diem recoupment of $10.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per-diem recoupment status, the non-compensable days of service will be reported in the notification. Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or anyone financially responsible for the member.~~ If the individual plan of care is missing or it is found that the child did not meet medical necessity criteria at any time, all paid services will be recouped for each day the individual plan of care was missing from the date the plan of care was due for completion.

317:30-5-744. Billing

~~(a) Claims will be submitted monthly for each eligible recipient. A claim for that particular individual should include all reimbursable services provided during a given month.~~

~~(b)~~(a) Claims must not be submitted prior to OHCA's determination of the ~~client's~~ member's eligibility and must not be submitted later than 1 year after the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from ~~Medicaid~~ SoonerCare funds can be made should the individual be determined eligible at a later date.

~~(c)~~(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the OHCA.

317:30-5-745. Documentation of records

All services must be reflected by documentation in the records including the date the service was provided, the beginning and ending time the service was provided, the location in which the service was provided, a description of the resident's response to the service and whether the service provided was an individual, group or family session, group rehabilitative treatment, social skills (re)development, basic living skills (re)development, crisis behavior management and redirection, or discharge planning, and the dated signature with credentials of the person providing the service.

8.c-1 CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 5. Eligibility and Countable Income
Part 3. Non-Medical Eligibility Requirements
Subchapter 6. Soonercare For Categorically
Needy Pregnant Women and Families with Children
Part 7. Certification, Redetermination and Notification
OAC 317:35-6-60. [AMENDED]
(Reference APA WF # 09-55)

SUMMARY: Effective in March 2010, the OHCA will assume responsibility for determining eligibility for certain groups of individuals under SoonerCare. The process will be phased in over a period of time, starting with the easiest groups who have no asset test and use income declaration: families with children, pregnant women, and individuals requesting only family planning services. As OHCA will now be determining eligibility for some of our population, parts of our eligibility rules and grievance rules are revised to incorporate these new responsibilities. In addition, eligibility for these three groups will no longer be retroactive to the first day of the month of application but will be effective the date of application or later unless otherwise prior approved by OHCA.

BUDGET IMPACT: Agency staff has determined that these revisions will be budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

PUBLIC HEARING: A public hearing was held February 17, 2010. The revised language regarding retroactive eligibility is being made to address providers' written and oral comments on this subject.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 6. SOONERCARE FOR CATEGORICALLY
NEEDY PREGNANT WOMEN AND FAMILIES WITH CHILDREN
PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the date of certification. The period of certification may not be for a retroactive period unless otherwise prior approved by OHCA. The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other household members in the case.

(1) **Certification as a TANF (cash assistance) recipient**. A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

(2) **Certification of non-cash assistance individuals categorically needy and related to AFDC**. The certification period for the individual related to AFDC is 12 months. The certification period can be less than 12 months if the individual:

(A) is certified as eligible in a money payment case during the 12-month period;

(B) is certified for long-term care during the 12-month period;

(C) becomes ineligible for SoonerCare after the initial month; or

(D) becomes ineligible as categorically needy.

(i) If an income change after certification causes the case to exceed the categorically needy maximums, the case is closed.

(ii) Individuals, however, who are determined pregnant and eligible as categorically needy continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy related services through the postpartum period.

(3) **Certification of individuals categorically needy and related to pregnancy-related services**. The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two months following the month the pregnancy ends. Eligibility as categorically needy is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(4) **Certification of newborn child deemed eligible**.

(A) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one. The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

(B) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. No other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at OKDHS. The referral enables child support services to be initiated.

(C) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one. If the child's eligibility is moved from the case where initial eligibility was established, it is

required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

(i) loses Oklahoma residence; or

(ii) expires.

(D) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

8.c-20 CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 1. General Provisions
OAC 317:35-1-2. [AMENDED]
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationship
OAC 317:35-5-2. [AMENDED]
OAC 317:35-5-7. [AMENDED]
Part 5. Countable Income and Resources
OAC 317:35-5-43. [AMENDED]
OAC 317:35-5-44. [AMENDED]
Subchapter 10. ~~Medical Aid to Families with Dependent Children~~ Other Eligibility Factors for Families with Children and Pregnant Women
Part 5. Income
OAC 317:35-10-26. [AMENDED]
Subchapter 17. ADvantage Waiver Services
OAC 317:35-17-3. [AMENDED]
Subchapter 21. Breast and Cervical Cancer Treatment Program
OAC 317:35-21-11. [AMENDED]
(Reference APA WF # 09-20)

SUMMARY: Medical Assistance for Adults and Children-Eligibility rules are revised to clarify rules used by employees of the Oklahoma Department of Human Services and the Oklahoma Health Care Authority when determining an individual's eligibility for Medicaid. The proposed revisions will: (1) incorporate current procedures and terminology; (2) remove obsolete language; and (3) update incorrect policy citations and form references. Revisions are needed to provide consistency and clarity within agency rules.

BUDGET IMPACT: Agency staff has determined that these revisions will be budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 21, 2010, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

PUBLIC HEARING: A public hearing was held February 17, 2010. No comments were received before, during, or after the hearing.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

The following words and terms, when used in this Chapter, have the following meaning, unless the context clearly indicates otherwise:

"Acute Care Hospital" means an institution that meets the requirements of 42 CFR, Section 440.10 and:

(A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) meets the requirements for participation in Medicare as a hospital.

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"AFDC" means Aid to Families with Dependent Children.

"Aged" means an individual whose age is established as 65 years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children" means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for Aid to Families with Dependent Children in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the Oklahoma Health Care Authority (OHCA).

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the Oklahoma Health Care Authority Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or "related" means the individual is:

(A) aged, blind, or disabled;

(B) pregnant;

(C) an adult individual who has a minor child under the age of 18 ~~and who is deprived of parental support due to absence, death, incapacity, unemployment~~; or

(D) a child under 19 years of age.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"County" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by the Oklahoma Department of Human Services.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for in-patient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays 80% of the allowable charge. The remaining 20% is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Local office" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age 65 or older and for those under age 65 who have been receiving disability benefits under these programs for at least 24 months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age 65 or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a Qualified Disabled and Working Individual (QDWI) under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of 18.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for the mentally retarded or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the Oklahoma Department of Human Services' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the Oklahoma Health Care Authority that assists with the eligibility determination process.

"OKDHS" means the Oklahoma Department of Human Services.

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a 12-month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care

Authority Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays are expected to last not less than 60 days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIP

317:35-5-2. Categorically related programs

(a) Categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, or is ~~low-income~~ under age 19, categorical relationship is automatically established. Categorical relationship to pregnancy-related services is established when the determination is made by medical evidence that the individual is or has been pregnant. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods. For an individual age 19 or over to be related to AFDC, the individual must have a minor dependent child. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the Family Planning Waiver Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one of the following:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Aid to Families with Dependent Children
(6) Refugee
(7) Breast and Cervical Cancer Treatment program
(8) Family Planning Waiver Program
(9) Benefits for pregnancies covered under Title XXI.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21 who are not receiving cash assistance under any program but who meet the income requirement of the State's approved AFDC plan.

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:

(A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma

Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or

(B) in adoptions subsidized in full or in part by a public agency; or

(C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18th birthday and living in an out of home placement.

317:35-5-7. Determining categorical relationship to AFDC

(a) All individuals under age 19 are automatically related to AFDC and further determination is not required. Adults age 19 or older are related to AFDC when there is a minor dependent child(ren) in the home and the individual is the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent child is any child who meets the AFDC eligibility requirements of age and relationship.

(b) ~~**CSED**~~ **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving ~~Medicaid benefits~~ SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with ~~CSED~~ OCSS. However, federal regulations provide for a waiver of this requirement when cooperation with ~~CSED~~ OCSS is not in the best interest of the child. ~~CSED~~ OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, his/her needs cannot be included in the benefit group unless ~~CSED~~ OCSS has determined good cause exists. There is no requirement of cooperation with ~~CSED~~ OCSS for a child(ren) only ~~Medicaid~~ SoonerCare case.

317:35-5-43. Third party resources; insurance, workers' compensation and Medicare

Federal Regulations require that all reasonable measures to ascertain legal liability of third parties to pay for care and services be taken. In instances where such liability is found to exist after ~~Title XIX~~ SoonerCare has been made available, reimbursement to the extent of such legal liability must be sought. ~~If the~~ The applicant or ~~recipient~~ member ~~has already received payments~~ must fully disclose to OHCA that another resource may be available to pay for care. If OKDHS obtains information regarding other available resources from a third party, the worker must complete OKDHS Form 08AD050E, ~~Third Party Liability Resources, is completed by OKDHS staff~~ and ~~submitted~~ submit to OHCA, Third Party Liability Unit. Certification or payment in behalf of an eligible individual may not be withheld because of the liability of a third party when such liability or the amount cannot be currently established or is not currently available to pay the individual's medical expense. The rules in this Section also apply when an individual categorically related to pregnancy-related services plans to put the child up for adoption. Any agreement with an adoption agency or attorneys shall include ~~for~~ payment of medical care and must be determined as a possible third party liability, regardless of whether agreement is made during prenatal, delivery or postpartum periods.

(1) **Insurance.**

(A) **Private insurance.** An individual requesting SoonerCare is responsible for identifying and providing information on any private

medical insurance. He/she is also responsible for reporting subsequent changes in insurance coverage. ~~The worker must explain the necessity for applying benefits from private insurance to the cost of medical care.~~

(B) **Government benefits.** ~~When an individual~~ Individuals requesting SoonerCare ~~is~~ who are also eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), ~~payment is not made from SoonerCare funds until the worker receives confirmation that other benefits are not available from this source~~ must disclose that the coverage is available. Payments from CHAMPUS for medical care are not considered as income in determining eligibility. They are, however, considered as third party liability sources.

(2) **Workers' Compensation.** ~~When an~~ An applicant for SoonerCare or a SoonerCare member that requires medical care because of work injury or occupational disease~~, the worker~~ must notify OHCA/TPL immediately and assist OHCA in ~~ascertains~~ ascertaining the facts related to the injury or disease (such as date, details of the accident, etc.) ~~and sends OKDHS Form 08AD050E to OHCA/TPL to be referred to the OKDHS Audit Unit of OIG~~. The ~~OKDHS Legal Division clears~~ OHCA periodically matches data with the ~~Industrial~~ Worker's Compensation Court on all cases under its jurisdiction. When any information regarding an applicant for SoonerCare or a SoonerCare member is obtained, ~~the OKDHS Legal Division sends a memo to OHCA asking for an itemization of claims paid~~ OHCA must then attempt to subrogate with the employer/insurer.

(3) **Third party liability (accident or injury).** When medical services are required for an applicant of SoonerCare or a SoonerCare member as the result of an accident or injury known to the worker, the ~~worker~~ member is responsible for ~~determining~~ reporting to OHCA/TPL the persons involved in the accident, date and details of the accident and possible insurance benefits which might be made available. If an automobile accident involves more than one car it is necessary to report liability insurance on all cars involved.

(A) If OKDHS receives information regarding a SoonerCare member or applicant seeking medical services due to an accident, ~~The~~ the worker completes OKDHS Form 08AD050E and submits it with any additional information available to ~~the appropriate OKDHS State Office Division where it is referred to the OKDHS Audit and Review Division for determination of liability for medical care. A copy of this referral is sent to OHCA, Third Party Liability~~ OHCA/TPL.

(B) If ~~such report has not been received from the county but the~~ OHCA receives a claim for payment from SoonerCare funds and the diagnosis indicates the ~~possibility the~~ need for services may have resulted from an accident or injury involving third party liability, OHCA ~~sends this information to the OKDHS Office of Inspector General.~~ will attempt to contact the member to obtain details of the incident. If additional contact is necessary with the member, ~~The~~ the local office may be requested by the ~~OKDHS Audit and Review Division~~ OHCA/TPL to submit OKDHS Form 08AD050E. The worker completes this form and submits it to the ~~OKDHS State Office, where the OKDHS Office of Inspector General will make any necessary follow-up and~~ OHCA/TPL to take the appropriate action.

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card or other verification, the worker clears with the Social Security Office and enters the findings and the date of the verification in the case record. If the applicant did not

enroll for Part A or Part B at the time he/she became eligible for Medicare and is now subject to pay an escalated premium for Medicare enrollment, he/she is not required to do so. Payment can be made for services within the scope of SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to AFDC, AB or AD and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS ~~DCFS~~ Children and Family Services Division (CFSD). The child support income continues to be counted in determining SoonerCare eligibility. The rules in OAC 317:10 are used, with the following exceptions:

(i) In the event the family already has an existing ~~Child Support Enforcement~~ child support case, the only action required is a memo to the appropriate ~~Child Support Enforcement~~ Oklahoma Child Support Services (OCSS) district office notifying them of the certification.

(ii) Child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the ~~CSED~~ OCSS or retained by the member.

(iii) Children who are in custody of OKDHS may be exempt from referral to ~~CSED~~ OCSS. Should the pursuit of the ~~CSED~~ OCSS services be determined to be detrimental to the OKDHS ~~DCFS~~ CFSD service plan, an exemption may be approved.

(B) Cash medical support may be ordered to be paid to the OHCA by the non-custodial parent if there is no access to health insurance at a reasonable cost or if the health insurance is determined not accessible to the child according to OKDHS Rules. Reasonable is deemed to be 5% or less of the non-custodial parent's gross income. The administration and collection of cash medical support will be determined by OKDHS ~~CSED~~ OCSS and will be based on the income guidelines and rules that are applicable at the time. However, at no time will the non-custodial parent be required to pay more than 5% of his/her gross income for cash medical support unless payment in excess of 5% is ordered by the Court. The disbursement and hierarchy of payments will be determined pursuant to ~~OKDHS-CSED~~ OKDHS/OCSS guidelines.

317:35-5-44. Child/spousal support

The Omnibus Budget Reconciliation Act of 1987 requires the Oklahoma Department of Human Services to provide Child Support ~~Enforcement~~ Services to certain families receiving ~~Medicaid~~ SoonerCare benefits ~~(MA, AB, AD)~~ through the Oklahoma Child Support Services Division (OCSS). The families are required to cooperate in assignment of medical support rights. These families will not be required to cooperate with the ~~Department of Human Services~~ OCSS in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to AFDC, AB or AD and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for

foster care child(ren) in ~~DHS~~ OKDHS temporary custody. This support is paid to ~~DHS DCFS~~ OKDHS Children and Family Services Division (CFSD). The child support income continues to be counted in determining ~~Medicaid~~ SoonerCare eligibility. The rules in OAC 317:10 are used, with the following exceptions:

(1) In the event the family already has an existing ~~Child Support Enforcement~~ child support case, the only action required is a memo to the appropriate ~~Child Support Enforcement~~ OCSS district office notifying them of the certification.

(2) Child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the ~~CSED~~ OCSS or retained by the ~~client~~ member.

(3) Children who are in custody of ~~DHS~~ OKDHS may be exempt from referral to ~~CSED~~ OCSS. Should the pursuit of the ~~CSED~~ OCSS services be determined to be detrimental to the ~~DHS DCFS~~ OKDHS CFSD service plan, an exemption may be approved.

SUBCHAPTER 10. ~~MEDICAL AID TO FAMILIES WITH DEPENDENT CHILDREN~~ OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

PART 5. INCOME

317:35-10-26. Income

(a) **General provisions regarding income.**

(1) The income of categorically needy individuals who are related to AFDC or Pregnancy does not require verification, unless questionable. If the income information is questionable, ~~the worker must verify the income~~ it must be verified. ~~The worker views all data exchange screens on all individuals included in the household size.~~ If ~~the data exchange screen reveals conflicting information, the worker must resolve the conflicting information and if necessary, request verification~~ there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma Department of Human Services (OKDHS). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within 30 days from the

date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. Pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) A nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to an AFDC or pregnancy related recipient who is not currently eligible for SSI, is not counted as income.

~~(B) The worker must ask applicants if they have received a lump sum payment during the month of application, any month during the application process or anticipate to receive a lump sum in the future. Members are asked at the time of periodic redetermination if the benefit group has received or is expecting to receive a lump sum. The worker provides an oral explanation, including examples of lump sum payments, how the rule effects other benefits and the importance of reporting anticipated receipt of a lump sum payment. The worker also offers counseling when there is indication of anticipated receipt, including voluntary withdrawal of the application or case closure and availability of free legal advice.~~

~~(C)~~ (B) Lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award.

~~(D)~~ (C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy.

~~(E)~~ (D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

~~(F)~~ (E) Recurring lump sum income received from any source for a period covering more than one month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

~~(G)~~ (F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six months, will be averaged and considered as income for the next six months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two months to establish the amount to be anticipated and considered for prospective budgeting.

(6) A caretaker relative can only be included in the benefit group when the biological or adoptive parent is not in the home. A stepparent can be included when the ~~natural or~~ biological or adoptive parent is either incapacitated or not in the home.

(A) Consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children ~~regardless of whether the caretaker relative's needs are or are not included~~. However, if that person is the stepparent, the policy on stepparent liability is applicable.

(B) If a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the ~~relative~~ caretaker relative. The income of the caretaker relative and the spouse who is not an SSI or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month.

(7) A stepparent can be included when the ~~natural or~~ biological or adoptive parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included.

(8) When there is a stepparent or person living in the home with the ~~natural~~ biological or adoptive parent who is not a spouse by legal marriage to or common-law relationship with the own parent ~~but who is acting in the role of a spouse~~, the worker determines the amount of income that will be made available to meet the needs of the child(ren) and the parent. Only contributions made in cash directly to the benefit group can be counted as income. In-kind contributions are disregarded as income. When the individual and the member state the individual does not make a cash contribution, further exploration is necessary. This statement can only be accepted after clarifying that the individual's contributions are only in-kind.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the "~~true~~ wage" prior to payroll deductions and/or withholdings.

(1) **Earned income from self-employment.** If the income results from the ~~individuals's~~ individual's activities primarily as a result of the ~~individuals's~~ individual's own labor from the operation of a business enterprise, the "earned income" is the total profit after deducting the business expenses (cost of the production). Money from the sale of whole blood or blood plasma is also considered as self-employment income subject to necessary business expense and appropriate earned income exemptions.

(A) Allowable costs of producing self-employment income include, but are not limited to, the identifiable cost of labor, stock, raw material, seed and fertilizer, interest payments to purchase income-producing property, insurance premiums, and taxes paid on income-producing property.

(i) The federal or state income tax form for the most recent year is used for calculating the income~~, if necessary,~~ only if it is representative of the individual's current situation. The individual's business records beginning the month income became representative of the individual's current situation is used if the income tax information does not represent the individual's current situation.

(ii) If the self-employment enterprise has been in existence for less than a year, the income is averaged over the period of time the business has been in operation to establish the monthly income amount.

(iii) Self-employment income which represents an annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(B) **Items not considered**. The following items are not considered as a cost of producing self-employed income:

(i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;

(ii) Net losses from previous periods;

(iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and

(iv) Federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.

(C) **Room and/or board.** Earned income from a room rented in the home is determined by considering 25% of the gross amount received as a business expense. If the earned income includes payment for room and board, 50% of the gross amount received is considered as a business expense.

(D) **Rental property.** Income from rental property is to be considered income from self employment if none of the activities associated with renting the property is conducted by an outside-person or agency.

(2) **Earned income from wages, salary or commission.** If the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll deductions and/or withholdings. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as any other earned income.

(3) **Earned income from work and training programs.** Earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year.

(4) **Individual earned income exemptions.** Exemptions from each individual's earned income include a monthly standard work related expense and child care expenses the individual is responsible for paying. Expenses cannot be exempt if paid through state or federal funds or the care is not in a licensed facility or home. Exempt income is that income which by law may not be considered in determining need.

(A) **Work related expenses.** The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group.

(B) **Child care expenses.** Disregard of child care expense is applied after all other income disregards.

(i) Child care expense may be deducted when:

(I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and

(II) the employed member whose income is considered must purchase care.

(ii) ~~Child care expenses must be verified and the~~ The actual amount paid for child care per month, ~~as paid,~~ up to a maximum of $200 for

a child under the age of two or $175 for a child age two or older may be deducted. ~~In considering the care expense, only actual work hours and travel time between work and the child care facility or child care home will be allowed.~~

~~(iii) In explaining child care expenses, the worker informs the individual that payment for care is the responsibility of the member and any changes in the plan for care must be reported immediately.~~

~~(iv)~~ (iii) Oklahoma law requires all child care centers and homes be properly approved or licensed; therefore, child care expenses can only be deducted if the child is in a properly licensed facility or receiving care from an approved in-home provider. ~~However, in cases where licensed dependent care facilities and/or approved in home providers are not available (e.g., night employment), and the member arranges for care outside the home, an immediate referral is made by OKDHS Form K-13 to the licensing worker for a licensing decision. The cost of child care can be considered until the worker receives notification from the licensing worker that the home does not meet licensing standards or registration. If licensing or registration is denied, the member will be allowed 30 days after notification to make other child care arrangements, during which time the child care exemption will continue to be allowed.~~

~~(v)~~ (iv) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the home meets applicable standards of State, local or Tribal law.

~~(vi)~~ (v) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.

(5) **Formula for determining the individual's net earned income.** Formulas used to determine net earned income to be considered are:

(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.

(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.

(c) **Unearned income.**

(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.

(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.

(3) **Minerals.** If the member owns mineral rights, only actual income from minerals, delayed rentals, or production is considered. Evidence is obtained from documents which the member has in hand. When the member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.

(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the member.

(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits are considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the member's award letter, or verification from SSA. ~~If the individual states that he/she does not receive OASDI, has a pending application or has been denied OASDI, this can be verified, if necessary, by use of TPQYC computer transaction.~~ Retirement benefits received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.

(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.

(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the member and/or dependents may be eligible to receive. In each case under consideration, information is obtained as to whether the member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.

(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed $30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached $30. At that time the portion exceeding $30 is counted as lump sum income. If the amount of a single gift exceeds $30, it is not inconsequential and the total amount is therefore counted. If the member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.

(9) **Grants.** Grants which are not based on financial need are considered income.

(10) **Funds held in trust by Bureau of Indian Affairs (BIA).** The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the social worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual member, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered. Funds held in trust by the BIA and not disbursed are considered unavailable.

(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as income.

(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual member, guardian or conservator, these disbursements must be resolved with the BIA. These disbursements indicate all or a portion of the account may be available to the individual member, guardian or conservator.

(C) When disbursements have been made, the worker verifies whether such disbursements were made to the member or to a third party vendor in payment for goods or services. Payments made directly from the BIA

to vendors are not considered as income to the member. Workers obtain documentation to verify services rendered and payment made by BIA.

(D) Amounts disbursed directly to the members are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is counted in the month received.

(d) **Income disregards.** Income that is disregarded in determining eligibility includes:

(1) Food Stamp benefits;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Education Grants (including work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. If the loan agreement is not written, OKDHS Form ~~ADM-103~~ 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form ~~Adm-103~~ 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;

(5) Indian payments (including judgement funds or funds held in trust) which are distributed per capita by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this paragraph, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;

(6) Special allowance for school expenses made available upon petition in writing from trust funds of the student;

(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six months in any calendar year;

(9) Payments for supportive services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(10) Payments to volunteers under the Domestic Volunteer Service Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;
(12) Any portion of payments, made under the Alaska Native Claims Settlement Act to an Alaska Native, which are exempt from taxation under the Settlement Act;
(13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;
(14) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(15) Earnings of a child who is a full-time student are disregarded;
(16) The first $50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;
(17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;
(18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or logo;
(19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;
(20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;
(21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(22) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(23) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by states, local governments and disaster assistance organizations;
(24) Interests of individual Indians in trust or restricted lands;
(25) Income up to $2,000 per year received by individual Indians, which is derived from leases or other uses of individually-owned trust or restricted lands;
(26) Any home produce from garden, livestock and poultry utilized by the member and his/her household for their consumption (as distinguished from such produce sold or exchanged);
(27) Any payments made directly to a third party for the benefit of a member of the benefit group;
(28) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;

(29) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and an other such complimentary payments; ~~and~~

(30) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;

(31) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-214);

(32) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);

(33) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);

(34) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and

(35) Wages paid by the Census Bureau for temporary employment related to Census activities.

(e) In computing monthly income, cents will be carried at all steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplies by 4.3.

(2) **Weekly.** Income received weekly is multiplied by 4.3.

(3) **Twice a month.** Income received twice a month is multiplied by 2.

(4) **Biweekly.** Income received every two weeks is multiplied by 2.15.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-3. ADvantage program services

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

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

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services

for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have mental retardation or a cognitive impairment related to the developmental disability.

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

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

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

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

(b) Home and Community Based Waiver Services are outside the scope of ~~state plan~~ Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable ~~Medicaid~~ SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate ~~Medicaid~~ SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap. To meet program cost effectiveness eligibility criteria, the annualized cost of a ~~client's~~ individual's ADvantage services cannot exceed the ADvantage program services expenditure cap unless approved by the ~~Administrative Agent (AA) under one of~~ Oklahoma DHS Aging Services Division (OKDHS/ASD) in accordance with the exceptions listed in (1)- (5) of this subsection. The cost of the service plan furnished to ~~a client~~ an individual may exceed the expenditure cap only when all of the increased expenditures above the cap are due solely to:

(1) a one-time purchase of home modifications and/or specialized medical equipment; and/or

(2) documented need for a temporary (not to exceed a 60-day limit) increase in frequency of service or number of services to prevent institutionalization; or

(3) expenditures are for ADvantage Hospice services;

(4) expenditures in excess of the cap are for prescribed drugs, which would be paid by ~~Medicaid~~ SoonerCare if the individual were receiving services in a nursing home; and/or

(5) expenditures are for Institution Transition Services, and the annualized expenditures for ADvantage services to ~~a client~~ an individual under any combination of ~~these~~ circumstances described under exceptions (1) through (5) can reasonably be expected to be no more than 200% of the individual cap.

(c) Services provided through the ADvantage waiver are:

(1) case management~~ or Comprehensive Home Care (CHC) case management~~;

(2) respite~~ or CHC in-home respite~~;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

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

(7) advanced supportive/restorative assistance~~ or CHC advanced supportive/restorative assistance~~;

(8) skilled nursing~~ or CHC skilled nursing~~;

(9) home delivered meals;
(10) hospice care;
(11) medically necessary prescription drugs within the limits of the waiver;
(12) personal care (state plan)~~,~~ or ADvantage personal care~~, or CHC personal care~~;
(13) Personal Emergency Response System (PERS);
(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
(15) Institution Transition Services; ~~and~~
(16) assisted living; and
~~(16)~~ (17) ~~Medicaid~~ SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

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

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

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

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

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

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

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

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

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

(4) if the ~~client's~~ individual's needs are being met, or do not require ADvantage services to be met, or if the ~~client~~ individual would not require institutionalization if needs are not met.
(5) if, after the service and care plan is developed, the risk to ~~client~~ individual's health and safety is not acceptable to the ~~client~~ individual, or to the interdisciplinary service plan team, or to the ~~AA~~ OKDHS/ASD.

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

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

~~(h) The AA provides OKDHS with notification that the client is no longer program eligible.~~

SUBCHAPTER 21. BREAST AND CERVICAL CANCER TREATMENT PROGRAM

317:35-21-11. Certification for BCC

(a) In order for a woman to receive BCC treatment services she must first be screened for BCC under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and found to be in need of treatment. Once determined to be in need of treatment the CDC screener determines that the woman:

(1) does not have creditable health insurance coverage,
(2) is under age 65,
(3) is a US citizen or qualified alien (see OAC 317:35-5-25),
(4) is a self declared Oklahoma resident,
(5) has provided her social security number,
(6) is willing to assign medical rights to TPL, and
(7) has declared all household income.

(b) If all of the conditions in subchapter (a) are met, the CDC screener assists the woman in completing the BCC application (OHCA BCC-1). The completed BCC-1 is forwarded to the OKDHS office.

(c) If all of the conditions in subchapter (a) are not met, an application is not completed.

(d) The OKDHS worker verifies that the screener is a CDC screener. The worker also establishes whether or not the woman is otherwise eligible for ~~Medicaid~~ SoonerCare. If the woman is not otherwise eligible for ~~Medicaid~~ SoonerCare, she is certified for the BCC program. If the woman is eligible under another ~~Medicaid~~ SoonerCare category, the application is certified in ~~the other Medicaid~~ that category.

(e) If a woman does not cooperate in determining her eligibility for other ~~Medicaid~~ SoonerCare programs, her BCC application is denied and the appropriate notice is computer generated. For example, a woman otherwise eligible for ~~Medicaid~~ SoonerCare, related to the low income families with children category, refuses to cooperate with ~~child support enforcement~~ the Oklahoma Child Support Services Division without good cause would not be eligible for the BCC program.

(f) If a woman in treatment for breast or cervical cancer contacts the OKDHS office and has not been through the CDC screening process, she is referred to the BCC program.

(g) An individual determined eligible for BCC may be certified the first day of the month of application or, if the individual had a medical service within three months prior to the application date, the first day of the first, second or third month prior to the month of application, provided the date of certification is not prior to the CDC Screen.

8.c-21 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-40. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 51. Habilitation Services
317:30-5-482. [AMENDED]
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
Subchapter 5. Member Services
Part 1. Agency Companion Services
317:40-5-3. [AMENDED]
317:40-5-8. [AMENDED]
317:40-5-11. [AMENDED]
Part 5. Specialized Foster Care
317:40-5-64. [AMENDED]
Part 9. Service Provisions
317:40-5-101. [AMENDED]
317:40-5-102. [AMENDED]
317:40-5-104. [AMENDED]
317:40-5-110. [AMENDED]
317:40-5-111. [AMENDED]
317:40-5-113. [AMENDED]
Part 11. Other Community Residential Supports
317:40-5-150. [AMENDED]
317:40-5-152. [AMENDED]
317:40-5-153. [AMENDED]
Subchapter 7. Employment Services Through Homes and Community-Based Services Waivers
317:40-7-12. [AMENDED]
317:40-7-21. [AMENDED]
(Reference APA WF # 09-72)

SUMMARY: Chapter 30 rules are revised to clarify provider eligibility requirements for Home and Community Based Services providers for persons with mental retardation or certain persons with related conditions. Additionally rules are amended to clarify the provision of dental services funded through the Home and Community Based Waiver; revise language relating to nutrition services; specify coverage limitations for occupational therapy services; specify that physical therapists and physical therapist assistants must have a non restricted license to provide services through the Home and Community Based Waiver; limit HTS providers residing in the same home as the member to no more than 40 hours per week of paid supports and direct members with a need for support greater than 40 hours per week to access the remainder of their support from staff residing outside of their home; clarify that HTS may not perform functions relating to other employment during the provision of HTS services; and clarify the services that can not be simultaneously provided during the time pre-vocational and supported employment services are being rendered.

Chapter 40 rules are revised to clarify levels of support, outside employment guidelines and termination guidelines for Agency Companion Services; specify a review and approval process for Habilitation Training Services (HTS) and clarify proper utilization of HTS; clarify termination of foster providers; clarify the process for provision of nutritional services; clarify requirements for architectural

modifications; clarify services and provider requirements relative to specialized medical equipment; clarify responsibilities of Adult Day Services and Daily Living Supports providers; clarify member eligibility for residence in a group home; clarify the process for documenting the need for an enhanced rate in an employment setting; and revise policy to limit state dollar reimbursement for absence of a member receiving Waiver services to not exceed 10% of the authorized units for employment services.

BUDGET IMPACT: Agency staff has determined that the rule revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 21, 2010, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

PUBLIC HEARING: A public hearing was held February 17, 2010. No comments were received before, during or after the hearing.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and Community-Based Services Waivers for persons with mental retardation or certain persons with related conditions

(a) **Introduction to HCBS Waivers.** The Medicaid Home and Community-Based Services (HCBS) Waiver programs are authorized in accordance with Section 1915(c) of the Social Security Act.

(1) Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) operates HCBS Waiver programs for persons with mental retardation and certain persons with related conditions. Oklahoma Health Care Authority (OHCA), as the State's single Medicaid agency, retains and exercises administrative authority over all HCBS Waiver programs. Oklahoma Medicaid is referred to hereinafter as SoonerCare.

(2) Each waiver allows for the provision of specific Medicaid-compensable services that assist members to reside in the community and avoid institutionalization.

(3) Waiver services:

(A) complement and supplement services available to members through ~~the Medicaid State Plan~~ SoonerCare or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) can only be provided to persons who are ~~Medicaid~~ SoonerCare eligible, outside of a nursing facility, hospital, or institution; and

(C) are not intended to replace other services and supports available to members.

(4) Any waiver service must be:

(A) appropriate to the member's needs; and

(B) included in the member's Individual Plan (IP).

(i) The IP:

(I) is developed annually by the member's Personal Support Team, per OAC 340:100-5-52; and
(II) contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.
(ii) Services are authorized in accordance with OAC 340:100-3-33 and 340:100-3-33.1.
(5) DDSD furnishes ~~case management,~~ targeted case management~~, and services~~ to members as a Medicaid State Plan service under Section 1915(g)(1) of the Social Security Act in accordance with OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have ~~entered into contractual agreements~~ a current provider agreement with OHCA to provide HCBS for persons with mental retardation or related conditions.
(1) All providers, except pharmacy, specialized medical supplies and durable medical equipment providers must be reviewed by OKDHS DDSD. The review process verifies:
(A) the provider meets the licensure, certification or other standards as specified in the approved HCBS Waiver documents; and
(B) organizations that do not require licensure wishing to provide HCBS services meet program standards, are financially stable and use sound business management practices.
(2) Providers who do not meet the standards in the review process will not be approved for a provider agreement.
(3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

(c) **Coverage.** All services must be included in the member's IP. Arrangements for services must be made with the member's case manager.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through ~~(13)~~ (15). Providers of any habilitation service must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS).
(1) **Dental services.** Dental services are provided per OAC 317:40-5-112.
(A) **Minimum qualifications.** Providers of dental services must have non-restrictive licensure to practice dentistry in Oklahoma by the Board of Governors of Registered Dentists of Oklahoma.
(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:
(i) oral examination;
(ii) bite-wing x-rays;
(iii) prophylaxis;
(iv) topical fluoride treatment;
(v) development of a sequenced treatment plan that prioritizes~~;~~:
(I) elimination of pain;
(II) adequate oral hygiene; and
(III) restoration or improved ability to chew;
(vi) routine training of member or primary caregiver regarding oral hygiene; and

(vii) ~~any other service recommended by a dentist~~ preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP), in accordance with applicable ~~Home and Community-Based Services (HCBS)~~ Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services**. Nutrition Services are provided per OAC 317:40-5-102.

~~(A) **Minimum qualifications.** Providers of nutrition services must be licensed by the Oklahoma State Board of Medical Examiners and registered as a dietitian with the Commission of Dietetic Registration.~~

~~(B) **Description of services.** Nutrition services include dietary evaluation and consultation in diet to members or their caregivers.~~

~~(i) Services are:~~

~~(I) intended to maximize the member's nutritional health; and~~

~~(II) provided in any community setting as specified in the member's IP.~~

~~(ii) A minimum of 15 minutes for encounter and record documentation is required.~~

~~(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 192 units per Plan of Care year.~~

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by the occupational therapist.

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of their practice.

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the member's IP. The IP must include a physician's prescription.

(ii) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician assistants~~, and advanced practice nurses~~ in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapy assistant within their employment. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

~~(i) Services provided by occupational therapy assistants must be identified on the claim form by the use of the occupational therapy assistant's individual provider number in the servicing provider field.~~

~~(ii) Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.~~

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapy assistants must ~~be~~ have a current non-restrictive ~~licensed~~ licensure with the Oklahoma State Board of Medical Licensure and Supervision. The physical therapy assistant must be employed by the physical therapist.

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include the use of physical therapy assistants, within the limits of their practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a physician's prescription.

(ii) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician assistants~~, and advanced practice nurses~~ in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapy assistant within their employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

~~(i) Payment is made for:~~

~~(I) compensable services to the individual physical therapist for direct services; or~~

~~(II) services provided by a qualified physical therapy assistant within his or her employment.~~

~~(ii) Services provided by physical therapy assistants must be identified on the claim form by the use of the physical therapy assistant's individual provider number in the servicing provider field.~~

~~(iii) Payment is:~~

~~(I) made in 15-minute units with a limit of 480 units per Plan of Care year; and~~

~~(II) not allowed solely for written reports or record documentation.~~

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires non-restrictive licensure as a psychologist by the Oklahoma Psychologist Board of Examiners, or licensing board in the state in which service is provided.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP.

(i) Services are:

(I) intended to maximize a member's psychological and behavioral well-being; and

(II) provided in individual and group, six person maximum, formats.

(ii) A minimum of 15 minutes for each individual encounter and 15 minutes for each group encounter and record documentation of each treatment session is included and required.

(C) **Coverage limitations.**

(i) Limitations for psychological services are:

(I) Description: Psychotherapy services and behavior treatment services (individual): Unit: 15 minutes; and

(II) Description: Cognitive/behavioral treatment (group): Unit: 15 minutes.

(ii) Psychological services are authorized for a period not to exceed six months.

(I) Initial authorization is through the Developmental Disabilities Services Division (DDSD) case manager, with review and approval by the DDSD case management supervisor.

(II) Initial authorization must not exceed 192 units (48 hours of service).

(III) Monthly progress notes must include a statement of hours and type of service provided, and an empirical measure of member status as it relates to each objective in the member's IP.

(IV) If progress notes are not submitted to the DDSD case manager for each month of service provision, authorization for payment must be withdrawn until such time as progress notes are completed.

(iii) Treatment extensions may be authorized by the DDSD area manager based upon evidence of continued need and effectiveness of treatment.

(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDSD case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.

(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human Services (OKDHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours (96 units) of service per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours (48 units) may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours (560 units) of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a provider of psychiatric services requires a non-restrictive license to practice medicine in Oklahoma. Certification by the Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, and medication and prescription management and consultation provided to members who are eligible. Services are provided in any community setting as specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of 30 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 30 minutes, with a limit of 200 units per Plan of Care year.

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a provider of speech/language services requires non-restrictive licensure as a speech/language pathologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor/feeding activities provided to members who are eligible. Services are intended to maximize the member's community living skills and may be provided in any community setting as specified in the member's IP. The IP must include a physician's prescription.

(i) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician assistants~~, and advanced practice nurses~~ in accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the OKDHS DDSD sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet the unique needs of members;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. ' 1025.2), unless a waiver is granted per 56 O.S. ' 1025.2; and

(iv) receive supervision and oversight from a contracted agency staff with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment will not be made for:

(I) routine care and supervision that is normally provided by family; or

(II) services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members who require more than 40 hours per week of HTS must use staff members who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of any necessary support staff hours.

(iii) Payment does not include room and board or maintenance, upkeep, and improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) DDSD case management supervisor review and approval is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an oversight agency approved by the OHCA. For pre-authorized HTS services, the service:

(I) provider will receive oversight from DDSD area staff; and

(II) must be pre-approved by the DDSD director or designee.

(C) **Coverage limitations.** HTS services are authorized as specified in OAC 317:40-5-110, 317:40-5-111, and 317:40-7-13, and OAC 340:100-3-33.1.

(i) A unit is 15 minutes.

(ii) Individual HTS services providers will be limited to a maximum of 40 hours per week regardless of the number of members served.

(iii) More than one HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.

(vi) HTS providers may not perform any job duties associated with other employment including on call duties, at the same time they are providing HTS services.

(9) Self Directed HTS (SD HTS).

SD HTS are provided per 317:40-9-1.

(10) Self Directed Goods and Services (SD GS).

SD GS are provided per 317:40-9-1.

~~(9)~~(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to members who are eligible. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a physician's prescription.

(i) For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, and physician

assistants~~, and advanced practice nurses~~ in accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the ~~service recipient's~~ member's IP.

~~(10)~~(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. ' 1025.2, unless a waiver is granted per 56 O.S. ' 1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.

(i) Prevocational services are provided to members who are not expected to:

(I) join the general work force; or

(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.

(ii) When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills.

(iii) All prevocational services will be reflected in the member's IP as habilitative, rather than explicit employment objectives.

(iv) Documentation must be maintained in the record of each member receiving this service noting that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(v) Services include:

(I) center-based prevocational services as specified in OAC 317:40-7-6;

(II) community-based prevocational services as specified in OAC 317:40-7-5;

(III) enhanced community-based prevocational services as specified in OAC 317:40-7-12; and

(IV) supplemental supports as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based upon the number of hours the member participates in the service. All prevocational services and supported employment services combined may not exceed $25,000 per Plan of Care year. The following services may not be provided to the same member at the same time as prevocational services:

(i) HTS;

(ii) Intensive Personal Supports;
(iii) Adult Day Services;
(iv) Daily Living Supports;
(v) Homemaker; or
(vi) therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training and as allowed per 317:40-7-6.

~~(11)~~(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. ' 1025.2, unless a waiver is granted per 56 O.S. ' 1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waiver, including supervision and training.

(i) When supported employment services are provided at a work site in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) job coaching as specified in OAC 317:40-7-7;

(II) enhanced job coaching as specified in OAC 317:40-7-12;

(III) employment training specialist services as specified in OAC 317:40-7-8; and

(IV) stabilization as specified in OAC 317:40-7-11.

(iii) Supported employment services furnished under HCBS Waiver are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA must be maintained in the record of each member receiving this service.

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) payments that are passed through to users of supported employment programs; or

(III) payments for vocational training that are not directly related to a member's supported employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made in accordance with OAC 317:40-7-1 through 317:40-7-21. All prevocational

services and supported employment services combined cannot exceed $25,000 per Plan of Care year. The DDSD case manager assists the member to identify other alternatives to meet identified needs above the limit. The following services may not be provided to the same member at the same time as supported employment services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) Therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

~~(12)~~(14) **Intensive personal supports (IPS).**

(A) **Minimum qualifications.** IPS provider agencies must have a current~~, valid contracts~~ provider agreement with OHCA and OKDHS DDSD. Providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. ' 1025.2, unless a waiver is granted per 56 O.S. ' 1025.2;

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities; and

(v) receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**

(i) IPS:

(I) are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, recreational, and habilitation activities.

(ii) The member's IP must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) DDSD case management supervisor review and approval is required.

(C) **Coverage limitations.** IPS are limited to 24 hours per day and must be included in the member's IP per OAC 317:40-5-151 and 317:40-5-153.

~~(13)~~(15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) meet the licensing requirements set forth in 63 O.S. ' 1-873 *et seq*. and comply with OAC 310:605; and

(ii) be approved by the OKDHS DDSD and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive, and socialization skills, including the opportunity to interact with peers

in order to promote maximum level of independence and function. Services are provided in a non-residential setting separate from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are typically furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for up to a maximum of six hours daily, at which point a unit is one day. All services must be authorized in the member's IP.

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 5. MEMBER SERVICES
PART 1. AGENCY COMPANION SERVICES

317:40-5-3. Agency companion services

(a) Agency companion services (ACS):

(1) are provided by agencies ~~contracted~~ that have a provider agreement with the Oklahoma Health Care Authority (OHCA);

(2) provide a living arrangement developed to meet the specific needs of the member that includes a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;

(3) are available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under the age of 18 years may be served with approval from the DDSD director or designee;

(4) are based on the member's need for residential services per OAC 340:100-5-22 and support as described in the member's Individual Plan (IP), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:

(1) must be employed by or contract with a provider agency approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD);

(2) may provide companion services for one member. Exceptions to serve as companion for two members may be granted only upon approved by the DDSD director or designee. Exceptions may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;

(3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the DDSD director or designee;

(4) may not provide companion services to more than two members at any time;

(5) household may not serve more than three members through any combination of companion or respite services;

(6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5.

(A) Employment as an agency companion is the companion's primary employment.

(B) The companion may not have other employment when~~:~~

~~(i) the member(s) require enhanced or pervasive level of support;~~

~~(ii)~~ approved to serve two members regardless of the levels of support required by the members.

(C) The companion may have other employment when:

~~(i) the member requires intermittent or close levels of support;~~

~~(ii)~~ (i) the personal support Team documents and addresses all related concerns in the member's IP; ~~and~~

~~(iii)~~ (ii) the other employment is approved in advance by the DDSD area manager or designee; and

(iii) the companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and

(iv) the companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.

~~(7) approved for other employment may not be employed in another position that requires on-call duties.~~

~~(A)~~ (D) If, after receiving approval for other employment, authorized DDSD staff determines the other employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within 30 days:

(i) the other employment; or

(ii) his or her employment as an agency companion.

~~(B)~~ (E) Homemaker, habilitation training specialist, and respite services are not provided in order for the companion to perform other employment.

(c) Each member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's salary.

(1) Therapeutic leave:

(A) is a SoonerCare payment made to the contract provider to enable the member to retain services; and

(B) is claimed when:

(i) the member does not receive ACS for 24 consecutive hours due to:

(I) a visit with family or friends without the companion;

(II) vacation without the companion; or

(III) hospitalization, regardless of whether the companion is present; or

(ii) the companion uses authorized respite time;

(C) is limited to no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year; and

(D) cannot be accrued from one Plan of Care year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate which is paid at the enhanced agency companion per diem rate.

(3) The provider agency pays the agency companion the salary that he or she would earn if the member were not on therapeutic leave.

(d) Levels of support for the member and corresponding payment are:

(1) determined by authorized DDSD staff in accordance with levels described in (A) through(D); and

(2) re-evaluated when the member has a change in agency companion providers which includes a change in agencies or individual companion providers.

(A) **Intermittent level of support**. Intermittent level of support is authorized when the member:

(i) requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;
~~(ii) communicates needs and wants;~~
~~(iii) is~~ (ii) may be able to spend short periods of time unsupervised inside and outside the home; and
~~(iv)~~(iii) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities~~; and~~.
~~(v) has stable or no ongoing medical or behavioral difficulties.~~

(B) **Close level of support**. Close level of support is authorized when the member:

(i) requires regular, frequent and sometimes constant physical assistance and support ~~or is totally dependent on others~~ to complete daily living skills, such as bathing, dressing, eating, and toileting;
~~(ii) has difficulty or is unable to communicate basic needs and wants;~~
~~(iii)~~ (ii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and
~~(iv)~~ (iii) requires ~~regular monitoring and~~ assistance with health, medication, or behavior interventions~~, and~~ that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support**. Enhanced level of support is authorized when the member:

(i) is totally dependent on others for:
(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and
(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;

(ii) demonstrates ongoing complex medical ~~or behavioral~~ issues requiring specialized training courses per ~~OAC 340:100-3-38.3; and~~ OAC 340:100-5-26; or
~~(iii) has medical support needs that are rated at Level 4, 5, or 6 on the Physical Status Review (PSR), per OAC 340:100-5-26. In cases where complex medical needs are not adequately characterized by the PSR, exceptions may be granted only upon review by the DDSD director or designee; or~~
~~(iv)~~ (iii) has behavioral issues that requires a protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must:
(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14;
(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, ~~and~~ or
(III) have received expedited approval per OAC 340:100-5-57.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:
(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system. The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

317:40-5-8. Agency companion services service authorization budget

Upon approval of the home profile per OAC 317:40-5-40, the companion, provider agency, the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) case manager, agency companion services (ACS) staff, and others as appropriate meet to develop a service authorization budget. ~~OKDHS Form 06AC074E,~~ The ~~Service Authorization Budget,~~ service authorization budget form is used to develop the individual service budget for the member's program and is updated annually by the member's Personal Support Team (Team).

(1) The companion receives:

(A) a salary based on the level of support needed by the member. The level of support is determined by authorized DDSD staff per OAC 317:40-5-3. The ACS rate for the:

(i) employer model includes funding for the provider agency for the provision of benefits to the companion; and

(ii) contractor model does not include funding for the provider agency for the provision of benefits to the companion; and

(B) any combination of hourly or daily respite per Plan of Care year to equal 660 hours in order to provide respite to the companion as reflected on ~~Form 06AC074E~~ the service authorization budget form.

~~(i)~~ (C) Habilitation training specialist (HTS) services:

(i) may be approved by the DDSD director or designee ~~if~~ when providing ACS with additional support represents the most cost-effective placement for the member and the member has an ongoing pattern of not:

(I) sleeping at night; or

(II) working or attending employment services, ~~in spite of~~ with documented and continuing efforts by the Team.

~~(ii) HTS units authorized must be reduced when the on-going situation changes.~~

(ii) may be approved when a time limited situation exists in which the ACS provider is unable to provide ACS and the provision of HTS will maintain the placement or provide needed stability to the member; and must be reduced when the situation changes.

(iii) ~~HTS authorizations~~ must be reviewed annually or more often if needed, which includes a change in agencies or individual companion providers.

(2) ~~OKDHS Form 6AC074E~~ The service authorization budget form reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the increase must be:

(A) agreed to by the member and, if applicable, legal guardian;

(B) recommended by the Team; and

(C) submitted with written justification attached to ~~OKDHS Form 06AC074E~~ the service authorization budget form to the DDSD area manager or designee for approval.

(3) ~~Prior to the meeting to discuss the service authorization budget, a~~ A back-up plan identifying respite staff is developed by the provider agency

program coordination staff and companion, prior to the meeting to discuss the service authorization budget.

(A) The back-up plan:

(i) is submitted to the DDSD case manager for approval and attached to the completed ~~OKDHS Form 06AC074E~~ service authorization form;

(ii) describes expected and emergency back-up support and program monitoring for the home; and

(iii) is signed by the companion, provider agency representative, and DDSD case manager.

(B) The companion and provider agency program coordination staff equally share the responsibility to identify approved respite providers who are:

(i) knowledgeable about the member;

(ii) trained to implement the member's Individual Plan (Plan);

(iii) trained per OAC 340:100-3-38; and

(iv) involved in the member's daily life.

(C) The spouse or other adult residing in the home may provide ACS in the absence of the companion, ~~if~~ when trained ~~in accordance with~~ per OAC 340:100-3-38. ~~The spouse or other adult residing in the home cannot:~~

~~(i) serve as paid respite staff; and~~

~~(ii) be paid simultaneously with the companion.~~

(D) The spouse or other adult residing in the home cannot serve as paid respite staff.

~~(D)~~ (4) The companion and respite staff are responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.

~~(4)~~ (5) The member is allowed therapeutic leave ~~in accordance with~~ per OAC 317:40-5-3.

317:40-5-11. Termination of Agency Companion ~~services~~ placement

(a) Designated Developmental Disabilities Services Division (DDSD) staff may terminate an individual agency companion (AC) placement for reasons including, but not limited to:

(1) the ~~service recipient's~~ member's decision to move to a different residence~~. A Team meeting is held to develop an orderly transition plan~~;

(2) the request of the companion~~. A Team meeting is held to develop an orderly transition plan~~;

(3) the Team determines the AC placement is no longer the most appropriate placement for the member;

~~(3)~~ (4) failure of the companion to complete tasks related to problem resolution, ~~as described in~~ per OAC 340:100-3-27, as agreed;

~~(4)~~ (5) confirmed abuse, neglect, or exploitation of any person;

~~(5)~~ (6) breach of confidentiality;

~~(6)~~ (7) involvement of the companion in criminal activity, or criminal activity in the home;

~~(7)~~ (8) failure to provide for the care and well-being of the ~~service recipient~~ member;

~~(8)~~ (9) continued failure to implement the Individual Plan, ~~as described in~~ per OAC 340:100-5-50 through 100-5-58;

~~(9)~~ (10) failure to complete and maintain training ~~as described in~~ per OAC 340:10-3-38;

~~(10)~~ (11) failure to report changes in the household ~~resulting in the failure of the home to meet standards given in OAC 317:40-5-40~~;

(12) failure or inability of the home to meet standards per OAC 317:40-5-40;
~~(11)~~ (13) continued failure to follow applicable Oklahoma Department of Human Services or Oklahoma Health Care Authority rules;
~~(12)~~ (14) decline of the companion's health to the point that he or she can no longer meet the needs of the ~~service recipient~~ member;
~~(13)~~ (15) employment by the companion without prior approval by the DDSD area programs manager for residential services; or
~~(14)~~ (16) domestic disputes which may result in emotional instability of the ~~person receiving services~~ member.

~~(c)~~(b) Upon termination of the placement~~,~~:
(1) the property of the ~~service recipient~~ member or the state is removed immediately by the ~~service recipient~~ member or his or her designee~~.~~; and
(2) the Team meets to develop an orderly transition plan.

(c) If an individual placement is terminated for reasons identified in (4)-(16) in this Section, DDSD staff will disapprove continued use of the companion.

PART 5. SPECIALIZED FOSTER CARE

317:40-5-64. ~~Closure~~ Termination of a Specialized Foster Care ~~home~~ Provider

(a) In the event that a provider fails to provide services as required by rules or contract, Developmental Disabilities Services Division (DDSD) ~~may, upon written notice to the provider, cancel certification of the home, effective upon receipt of notice~~ notifies the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS) Contracts Unit, to terminate the Specialized Foster Care (SFC) provider's contract. Such ~~cancellation~~ termination is not an exclusive remedy but is in addition to any other rights and remedies provided by law.

(b) Possible reasons for ~~closure~~ termination of a ~~Specialized Foster Care (SFC) home~~ provider include, but are not limited to:
(1) provider request;
(2) non-cooperation in determining compliance with standards, policy, or contract;
(3) confirmed abuse, neglect, or exploitation of any other person;
(4) breach of confidentiality;
(5) involvement in criminal activity or criminal activity in the home;
(6) failure to provide for the care and well-being of the ~~service recipient~~ member;
(7) continued failure to implement the ~~service recipient's~~ member's Plan;
(8) failure to complete and maintain required provider training;
(9) failure to report changes in the household ~~resulting in the failure of the home to meet standards~~;
(10) continued failure to follow ~~DDSD~~ OKDHS or OHCA ~~policy~~ rules;
(11) decline of the provider's health to the point that he or she can no longer meet the needs of the ~~service recipient~~ member;
(12) employment by the provider without prior approval by the ~~Developmental Disabilities Services Division (DDSD) SFC supervisor~~ area program manager for residential services;
(13) domestic disputes that may result in emotional instability of the ~~service recipient~~ member; ~~or~~
(14) failure to complete a ~~Plan of Action~~ plan of action, ~~as described in~~ per OAC 317:40-5-63, as agreed~~.~~; or
(15) failure or inability of the home to meet standards per OAC 317:40-5-40.

(c) ~~**Closure**~~ **Termination Process**. When necessary to ~~close an~~ terminate a SFC ~~home~~ provider, the steps described in this Subsection are taken.

(1) ~~SFC~~ DDSD staff documents~~,~~ in the provider case narrative, a summary of the reasons for ~~closure~~ termination and the effective date ~~of the closure~~.

(2) The DDSD ~~Area Manager~~ area manager or designee notifies the case manager and case manager supervisor to ~~make~~ notify legally responsible person(s) and identify other living arrangements, if applicable, for the ~~service recipient~~ member.

(3) The DDSD programs manager for residential services sends a 30-day written notice of the ~~closure~~ termination to the provider.

(A) A copy of the 30-day notice is sent to:

(i) the case manager;

(ii) case management supervisor;

(iii) DDSD ~~Area Manager~~ area manager;

(iv) DDSD State Office; and

(v) ~~Division of Children and Family Services (DCFS)~~Children and Family Services Division (CFSD), if applicable.

(B) A copy of the narrative is sent with the written notice to DDSD State Office;

(4) DDSD State Office notifies the ~~Oklahoma Health Care Authority~~ OHCA and the OKDHS Contracts Unit to ~~close~~ terminate the provider's contract.

PART 9. SERVICE PROVISIONS

317:40-5-101. Architectural modifications

(a) **Applicability.** The rules in this Section apply to architectural modification (AM) services authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

~~(a)~~ (b) **General information.** Architectural ~~modifications are performed by providers who have contractual agreements with the Oklahoma Health Care Authority to provide Home and Community-Based Services (HCBS) to the home of an eligible member with accessibility, behavioral, sensory, or environmental difficulties to enhance the member's independence and safety.~~ Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services. Providers must meet requirements of the International Code Council (ICC), formerly the Building Official and Code Administrators (BOCA), for building, electrical, plumbing and mechanical inspections;

(2) include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities, specialized safety adaptations such as scald protection devices, stove guards, and modifications required for the installation of specialized equipment, which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home;

(3) must be recommended by the member's Team and included in the member's IP. Arrangements for this service must be made through the member's case manager;

(4) are performed on homes of eligible members who have disabilities that limit accessibility or require modifications to ensure health and safety;

~~(1)~~(5) ~~Architectural modifications~~ are provided based on the:

(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);

(B) scope of architectural modifications per OAC 317:40-5-101;

(C) most appropriate and cost effective bid, if applicable, ensuring the quality of materials and workmanship;

(D) ~~availability~~ lack of a less expensive equivalent, such as assistive technology, that meets the member's needs~~.~~ ; and

(E) safety and suitability of the home.

~~(2)~~(6) ~~Necessary architectural~~ are limited to modifications ~~may be provided for each member for no more than~~ of two different residences within any ~~five~~ seven year period beginning with the member's first request for an approved architectural modification service~~.~~ ;

(7) are provided with assurance of plans for the member to remain in the residence for at least five years;

~~(3)~~ (8) ~~The Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD)~~ may be ~~deny~~ denied ~~authorization for architectural modifications services to the home of a member~~ when DDSD determines the home is unsafe or otherwise unsuitable for architectural modifications.

(A) DDSD area office resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.

(B) Members needing home modification services and provider agencies assisting members to locate rental property ~~recommend~~ identify several homes, when possible, for screening in order ~~that~~ to select a home with ~~minimal~~ the fewest or most cost effective modifications ~~may be selected.~~;

~~(4)~~(9) ~~Architectural modifications~~ are provided~~,~~ to eligible members with the homeowner's signed permission~~, to eligible members whether the member's home is rented or owned.~~ ;

~~(5) Only modifications that are specific to the member's unique needs are authorized.~~

~~(6)~~(10) ~~Architectural modifications~~ are not ~~used~~ authorized to modify homes solely for family or staff convenience or for cosmetic preference~~.~~ ;

~~(7)~~(11) ~~Modifications~~ are provided on finished rooms complete with wiring and plumbing~~.~~ ;

~~(8)~~(12) ~~The DDSD director or designee may approve written requests for exceptions to requirements of OAC 317:40-5-1-1 in exceptional circumstances.~~ services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDSD division administrator or designee in exceptional circumstances; and

~~(9)~~(13) ~~Authorization of architectural modifications complies~~ are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., §85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable statutory provisions.

~~(b)~~ (c) **Assessment and Team process.**

(1) Architectural modification assessments are performed by:

(A) DDSD area office resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or

(B) a licensed occupational therapist or physical therapist, at the request of designated DDSD area office resource development staff or area program supervisory staff, when the requested architectural modification ~~does not comply~~ exceeds or requires a variance to applicable national standards for persons with physical disabilities~~, as applicable to private homes~~ or when such expertise is deemed necessary by DDSD area office resource development staff or area program supervisory staff.

(2) The Team considers the most appropriate architectural modifications based on the:

(A) member's ~~present~~ needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) ~~are needed by the member to achieve an activity that is:~~ are necessary to ensure the health, welfare, and safety of the member; and

~~(i) meaningful to the member and requires another person to perform the activity, if the member cannot perform the activity independently, such as self care, eating, or transfers; and~~

~~(ii) age appropriate, considering the member's level of functioning; and~~

(B) ~~enhance the member's ability to:~~ provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

~~(i) improve or maintain health and safety;~~

~~(ii) participate in community life;~~

~~(iii) establish meaningful relationships;~~

~~(iv) express choices; or~~

~~(v) live with dignity.~~

~~(C)~~ (d) **Requirements and standards for architectural modification contractors and construction.** All contractors must meet applicable state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed; ~~and~~

(B) following all applicable building codes~~.~~ ; and

(C) taking and providing pictures to area office resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. Area office resource development staff may take pictures of the completed architectural modification projects when requested by the contractor.

(2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.

(3) New contractors must provide three references of previous work completed.

(4) Contractors must provide evidence of:

(A) liability insurance;

(B) vehicle insurance; and

(C) worker's compensation insurance or affidavit of exemption.

~~(d) **Standards for construction of architectural modifications.** All modifications are made in accordance with local and state housing codes, and permits are the sole responsibility of the contractor.~~

~~(1)~~ (5) All modifications meet ~~the applicable~~ national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.

~~(2)~~ (6) Contractors complete construction in compliance with written assessment recommendations ~~and addenda~~ from the:

(A) DDSD area office resource development staff with architectural modification experience~~, when the requested architectural modification complies with applicable national standards for persons with physical disabilities as applicable to private homes~~; or

(B) a licensed professional.

~~(3)~~ (7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.

~~(4)~~ (8) Ramps are constructed using the standards in (A) through (G) of this paragraph.

(A) All exterior wooden ramps are constructed of number two pressure treated wood.

(B) Surface of the ramp has a rough, non-skid texture.

(C) Ramps are assembled by the use of deck screws.

(D) Hand rails on ramps, if required, are sanded and smooth.

(E) Ramps can be constructed of stamped steel.

(F) Support legs on ramps are no more than six feet apart.

(G) Posts on ramps must be set or anchored in concrete.

~~(5)~~ (9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.

(A) The roll-in shower includes a new floor that ~~is sloped at least two inches from the outside walls down to the drain, when space permits. When space does not permit, the floor slopes as much as is possible and appropriate~~ slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.

(B) The material around the drain is flush, without an edge on which water can catch before going into the drain.

(C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 ~~to 36~~ inches up from the floor, with green board above the duro-rock.

(D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

(F) Roll in showers may also be constructed with a one piece pre-formed material.

~~(6)~~ (10) DDSD area office resource development staff ~~inspects~~ inspect any or all architectural modification work ~~and takes pictures of the final project~~, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) **Architectural modifications when members change residences.**

(1) When two or more members share a home that ~~was~~ has been ~~architecturally~~ modified ~~using state or HCBS Waiver funds,~~ and the member will no longer be sharing the home, the member whose Plan of Care ~~includes~~ authorized the modifications is given the first option of remaining in the residence ~~if the roommates no longer wish to share a home~~.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class~~,~~ when a written agreement between the homeowner and DDSD director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement exists between the DDSD director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) **Services not covered under architectural modifications.** ~~Architectural modification services make homes accessible according to the member's specific needs.~~ Architectural modifications do not include adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the member, construction, reconstruction, or

remodeling of any existing construction in the home, such as floors, sub-floors, foundation work, roof, or major plumbing.

(1) ~~No square~~ Square footage is not added to the home as part of ~~the~~ an architectural modification ~~process~~.

(2) ~~The OKDHS does not authorize payment or provide any architectural modification~~ Architectural modifications are not performed during construction or remodeling of a home ~~that is owned or being built for the member or his or her family~~.

(3) Modifications ~~that are~~ not ~~considered architectural modifications and cannot be~~ authorized by the OKDHS include, but are not limited to:

(A) roofs;
(B) installation of heating or air conditioning units;
(C) humidifiers;
(D) water softener units;
(E) fences;
(F) sun rooms;
(G) porches;
(H) decks;
(I) canopies;
(J) covered walkways;
(K) driveways;
(L) sewer lateral lines or septic tanks;
(M) foundation work;
(N) room additions;
(O) carports;
(P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as described in applicable national standards for persons with physical disabilities as applicable to private homes;
(Q) non-adapted home appliances;
(R) carpet or floor covering~~, unless documented as necessary to aid the member in mobility; and~~ that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or
(S) ~~walk in bathtubs~~ a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless~~:~~ needed by the member to move between the house and vehicle.

~~(A) needed by the member to move between the house and behicle; and~~
~~(B) AUTHORIZED BY THE ddsd DIRECTOR OR DESIGNEE. The DDSD director or designee may consaider other sidewalk needs.~~

(g) **Approval or denial of architectural modification ~~requests~~ services.** DDSD approval or denial of ~~the~~ an architectural modification ~~request~~ service is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request ~~sent~~ provided by the DDSD case manager to DDSD area office resource development staff includes:

(A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;
(B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101~~(b)~~; ~~and~~
(C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months~~.~~ ; and
(D) an assurance by the member or legal guardian, if applicable, that the member plans to reside in the residence for five years.

(2) ~~Prior to authorization of architectural modification services, at least three competitive bids are obtained for services costing $750 or more.~~ The DDSD area office:

(A) authorizes architectural modification services ~~up to~~ less than $2500~~;~~ when the plan of care is less than the state office reviewer limit; and

~~(B) is responsible for all required documentation; and~~

~~(C)~~ (B) ~~sends~~ provides all ~~necessary~~ required information to the DDSD State Office architectural modification programs manager for authorization of services ~~costing~~ when the plan of care is more than the area office limit or is $2500 or more.

(3) ~~If the DDSD area office resource development staff, therapist, or Team determines the service is not appropriate, the DDSD area office resource development staff or DDSD State Office Programs manager for architectural~~ Architectural modifications ~~provides a brief report describing the reason for the denial to the DDSD case manager~~ may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals**. The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.

317:40-5-102. Nutrition Services

(a) ~~**Purpose**~~ **Applicability.** The rules in this Section ~~are established to ensure that~~ apply to nutrition services authorized for members ~~to sustain quality of life and ensure optimal nutritional status are provided to individuals with developmental disabilities~~ who receive services through Home and Community-Based Services (HCBS) ~~Waiver services~~ Waivers operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD).

(b) **General information.** Nutrition services include nutritional evaluation and consultation to members and their caregivers, are intended to maximize the member's health and are provided in any community setting as specified in the member's Individual Plan (IP). Nutrition services must be prior authorized, included in the member's Individual Plan (IP) and arrangements for this service must be made through the member's case manager. Nutrition service contract providers must be licensed in the state where they practice and registered as a dietitian with the Commission of Dietetic Registration. Each dietitian must have a current provider agreement with the Oklahoma Health Care Authority (OHCA) to provide Home and Community Based Services, and a SoonerCare provider agreement for nutrition services. Nutrition Services are ~~based on the individual's need~~ provided per Oklahoma Administrative Code (OAC) 340:100-3-33.1. ~~as specified by the Individual Plan and include evaluation of the service recipient's nutritional status.~~

In order for the member to receive Waiver-funded nutrition services, the requirements in this Section must be fulfilled.

~~(1) If nutrition services from funding sources other than Waiver services are available to the service recipient, the service recipient uses those services before using Waiver services. In order for the service recipient to receive Waiver-funded nutrition services, the requirements in this Section must be fulfilled.~~

~~(2) A legally competent adult or legal guardian who has been informed of the risks and benefits of the service has the right to refuse nutrition services.~~

~~(A) Refusal of nutrition services must be documented in the Individual Plan.~~

~~(B) If the service recipient has been receiving nutrition services and nutritional status is currently stable, the Team may specify that nutrition services are not needed. The Team specifies individual risk factors for the service recipient that would necessitate resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the service recipient's status regarding these factors.~~

~~(3) Staff of the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) and contract agents implement procedures for nutritional risk identification, implementation of needed services, and nutritional risk monitoring to maintain and improve the nutritional health status of each person served.~~

(1) The member must be assessed by the case manager to have a possible eating problem or nutritional risk.

(2) The member must have a physician's order for nutrition services current within one year.

(3) Per OAC 340:100-5-50 through 58, the team identifies and addresses member needs.

(4) Nutrition services may include evaluation, planning, consultation, training and monitoring.

(5) A legally competent adult or legal guardian who has been informed of the risks and benefits of the service has the right to refuse nutrition services per OAC 340:100-3-11. Refusal of nutrition services must be documented in the Individual Plan.

(6) A minimum of 15 minutes for encounter and record documentation is required.

(7) A unit is 15 minutes.

(8) Nutrition services are limited to 192 units per Plan of Care year.

~~(c) **Services for persons not receiving residential supports.** If the service recipient does not receive residential supports as defined in OAC 340:100-5-22.1, or group home services:~~

~~(1) the Individual Plan must justify the need for nutrition services as described in OAC 340:100-3-33.1, Criteria to establish service necessity; and~~

~~(2) procedures described in subsections (e) through (j) are followed unless other procedures are approved in writing by the DDSD area manager or designee.~~

~~(d) **Services for persons receiving residential supports.** If the service recipient receives residential supports as defined in OAC 340:100-5-22.1, or group home services:~~

~~(1) the service recipient must have an updated OKDHS Form DDS-7, Physical Status Review (PSR), in accordance with OAC 340:100-5-26, identifying an eating problem or nutritional risk. indicated by a score of 3 or 4 on Eating, 4 on Gastrointestinal, 4 on Skin Breakdown, 4 on bowel Function, or 3 or 4 on the Nutrition section of the PSR. The Team must address these risks in the Individual Plan and identify appropriate professional oversight; and~~

~~(2) the requirements in subsections (e) through (j) of this Section are followed.~~

~~(e)~~ (c) ~~**Assessment**~~ **Evaluation.** When arranged by the case manager, the ~~The~~ nutrition ~~therapist~~ services contract provider evaluates the member's ~~service recipient's~~ nutritional status and completes the ~~OKDHS Form DDS-40,~~ Level of Nutritional Risk Assessment.

(1) The evaluation ~~assessment~~ must include, but is not limited to:

(A) health, diet, and behavioral history impacting on nutrition;
(B) clinical measures including body composition and physical assessment.
(C) dietary assessment, including:
(i)nutrient needs;
(ii) eating skills;
(iii) nutritional intake; and
(iv) drug-nutrient interactions; and
(D) recommendations to address nutritional risk needs, including:
(i) outcomes;
(ii) strategies;
(iii) staff training; and
(iv) program monitoring and evaluation.

(2) The nutrition services contract provider ~~therapist~~ and other involved professionals make recommendations for achieving positive nutritional outcomes based on the risks identified on the OKDHS Level of Nutritional Risk Assessment. ~~form DDS-40.~~

(3) The nutrition services contract provider ~~therapist~~ sends a copy of the Level of Nutritional Risk Assessment ~~DDS-40~~ to the case manager within ten working days of receipt of the authorization.

(4) If the ~~assessment~~ evaluation shows the member ~~service recipient~~ rated as "High Nutritional Risk", the nutrition services contract provider ~~therapist~~ sends a copy of the Level of Nutritional Risk Assessment ~~DDS-40~~ to the DDSD area nutrition therapist or DDSD area professional support services designee as well as the case manager within 10 working days of receipt of the authorization.

~~(f)~~(d) **Planning.** The DDSD case manager, in conjunction with the Team, reviews the identified nutritional ~~issues~~ risks that impact the member's ~~service recipient's~~ life.

(1) Desired nutritional outcomes are developed and integrated into the Individual Plan using the least restrictive, least intrusive, most normalizing measures that can be carried out across environments.

(2) The Team member(s) identified responsible in the Individual Plan develops methods to support the nutritional outcomes, which may include:
(A) Stragegies;
(B) Staff training; or
(C) Program monitoring.

(3) When the member has been receiving nutrition services and nutritional status is currently stable and the Team specifies that nutrition services are no longer needed, the Team will identify individual risk factors for the member that would indicate consideration of the resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the members status regarding these factors.

~~(1)~~(4) Any ~~service recipient with a PSR score of 3 or above on Section A, Eating,~~ member who receives paid 24 hour per day supports and requires constant physical assistance and mealtime intervention to eat safely, or is identified for risk of choking or aspiration must have an individualized mealtime assistance plan developed and reviewed at least annually by the Team member(s) identified responsible in the Individual Plan. Team members may include a nutrition services contract provider and a speech therapy contract provider or occupational therapy contract provider with swallowing expertise (mealtime therapists). Documentation should delineate responsibilities to insure there is no duplication of services. The mealtime assistance plan includes but is not limited to:
(A) a physician ordered diet ~~or meal plan~~;
(B) diet instructions;

~~(B)~~ (C) positioning needs;
~~(C)~~ (D) ~~adaptive equipment~~ assistive technology needs;
~~(D)~~ (E) communication needs;
(F) eating assistance techniques;
(G) supervision requirements;
~~(E) food presentation;~~
~~(F)~~ (H) documentation requirements;
~~(G)~~ (I) monitoring requirements; and
~~(H)~~ (J) training and assistance ~~requirements~~.

~~(2) In accordance with OAC 340:100-5-26, the Team:~~

~~(A) discusses any gastrostomy or jejunostomy tube placement, including discussion of less intrusive alternatives, prior to implementation of the proposed procedure; or~~

~~(B) reviews emergency placement of any gastrostomy or jejunostomy tube within five working days after placement.~~

(5) For those members receiving paid 24 hour per day supports and nutrition through a feeding tube, the Team develops and implements strategies for tube feeding administration that enables members to receive nutrition in the safest manner and for oral care that enables optimal oral hygiene and oral-motor integrity as deemed possible per OAC 340:100-5-26. The Team reviews the member's ability to return to oral intake following feeding tube placement and annually thereafter in accordance with the member's needs.

~~(3) The Team annually develops, and documents in the Individual Plan a review of, a plan for return to oral intake, in accordance with individual needs, for each service recipient who receives nutrition through a tube.~~

~~(4) Desired nutritional outcomes are developed and integrated into the Individual Plan using the least restrictive, least intrusive, most normalizing measures that can be carried out across environments.~~

~~(5) The Team member(s) identified responsible in the Individual Plan develops methods to support the nutritional outcomes, which include:~~

~~(A) implementation strategies;~~

~~(B) staff training; and~~

~~(C) program monitoring.~~

~~(g)~~(e) **Implementation, Consultation and Training.** Strategies are implemented by the assigned person within a designated time frame established by the Team based on individual need(s).

(1) Direct support staff members are trained ~~in accordance with~~ per the Individual Plan and OAC 340:100-3-38.

(2) All special diets, nutritional supplements, and aids to digestion and elimination must be prescribed and reviewed at least annually by a physician.

(3) Consultation to members and their caregivers is provided as specified in the IP.

~~(h)~~(4) ~~**Documentation.**~~ Program documentation ~~as determined necessary by the Team~~ is maintained in the ~~service recipient's~~ member's home record for the purpose of evaluation and monitoring. ~~The professional provider(s) sends documentation regarding the service recipient's progress on the nutrition outcomes, program concerns, and recommendations for remediation of any problem area to the case manager each month, or as often as deemed necessary by the Team.~~

(5) The contract professional provider(s) sends documentation regarding the member's program concerns, recommendations for remediation of any problem area and progress notes to the case manager per OAC 340:100-5-52.

~~(i) **Evaluation and monitoring.** A review to evaluate the success of the program is performed at least once each month or as deemed necessary in the~~

~~Individual Plan by the professional(s) designated by the Team. The area manager or designee may require a specified schedule for service recipients with a high nutritional risk.~~

~~(1)~~ (A) The designated professional(s) reviews the program data submitted for:

~~(A)~~ (i) completeness;

~~(B)~~ (ii) consistency of implementation; and

~~(C)~~ (iii) positive outcomes.

~~(2) DDSD professional support services personnel provide administrative oversight and quality assurance monitoring on an ongoing basis to service recipients with eating risk or nutritional risk identified through the PSR using:~~

~~(A) on-site visits; and~~

~~(B) record reviews.~~

~~(3)~~(B) When a ~~service recipient~~ member is identified by the Level of Nutritional Risk Assessment ~~DDS-40~~ to be at high nutritional risk, he or she receives increased monitoring by~~:~~

~~(A)~~ the nutrition services contract provider ~~therapist~~ and health care coordinator, as determined necessary by the Team.~~; and~~

~~(B) the DDSD area nutrition therapist or DDSD area professional support services designee.~~

~~(4)~~ (C) Significant changes in nutritional status must be reported to the case manager by the health care coordinator.

~~(5)~~ (D) The Level of Nutritional Risk Assessment ~~DDS-40~~:

~~(A)~~(i) is used by the ~~contract~~ nutrition services contract provider to reassess ~~service recipients~~ members at high risk on a quarterly basis; and

~~(B)~~(ii) must be submitted by the ~~contract~~ nutrition services contract provider to the DDSD area nutrition therapist or DDSD area professional support services designee within 15 days following the end of each quarter ~~(March, June, September, December)~~.

~~(6) The DDSD area nutrition therapist or designee, in conjunction with DDSD support services professionals, provides technical assistance to resolve individual nutrition issues and makes recommendations for additional technical assistance if needed.~~

~~(j) **Technical Assistance.** Professional contract providers serving as management consultants provide technical assistance as authorized. Technical assistance may be requested using OKDHS form DDS-41, Physical-Nutritional Management Consultation Request, by the Team or DDSD support services staff to address:~~

~~(1) unresolved nutritional management issues;~~

~~(2) gastrostomy or jejunostomy tube placement or removal;~~

~~(3) individualized mealtime assistance plan development; or~~

~~(4) any aspect of assessment, planning, implementation, evaluation, or monitoring of nutrition services.~~

317:40-5-104. Specialized medical supplies

(a) **Applicability.** The rules in this section apply to specialized medical supplies provided through Home and Community Based Services (HCBS) Waivers operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD).

~~(a)~~(b) **General ~~requirements~~ information.** Specialized medical supplies include supplies specified in the plan of care ~~that meet the criteria given in this Section.~~ that enable the member to increase his or her ability to perform activities of daily living. ~~(1)~~ Specialized medical supplies include

the purchase of ancillary supplies not available ~~under the Medicaid State Plan~~ through SoonerCare.

(1) Specialized medical supplies must be included in the member's plan and arrangements for this service must be made through the member's case manager. Items reimbursed with Home and Community Based Services ~~(HCBW)~~ (HCBS) funds are in addition to any supplies furnished ~~under the Medicaid State Plan~~ by SoonerCare.

(2) Specialized medical supplies meet the criteria for service necessity given in OAC 340:100-3-33.1.

(3) All items meet applicable standards of manufacture, design, and installation.

(4) Specialized medical supplies providers must hold a current SoonerCare Durable Medical Equipment (DME) and/or Medical Supplies Provider Agreement ~~contract~~ with the Oklahoma Health Care Authority~~.~~, and be registered to do business in Oklahoma or the state in which they are domiciled. Providers must enter into the agreement giving assurance of ability to provide products and services and agree to the audit and inspection of all records concerning goods and services provided.

(5) Items that can be purchased as specialized medical supplies include:

(A) incontinence supplies, as described in subsection (b) of this Section;

(B) nutritional supplements;

(C) supplies for respirator or ventilator care;

(D) decubitus care supplies;

(E) supplies for catheterization; and

(F) supplies needed for health conditions.

(6) Items that cannot be purchased as specialized medical supplies include:

(A) over the counter medications(s);

(B) personal hygiene items;

(C) medicine cups;

(D) items that are not medically necessary; and

(E) prescription medication(s)~~;~~ . ~~and~~

~~(F) items available through the Medicaid State Plan. Items available through the Medicaid State Plan must be exhausted before waiver-funded services can be accessed.~~

(7) Specialized medical supplies must be:

(A) necessary to address a medical condition;

(B) of direct medical or remedial benefit to the ~~service recipient~~ member;

(C) medical in nature; and

(D) consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability.

~~(b)~~ (c) **Limited coverage.** Items available in limited quantities through specialized medical supplies include:

(1) incontinence wipes, 300 wipes per month;

(2) non-sterile gloves, as approved by the Team;

(3) disposable underpads, 60 pads per month; and

(4) incontinence briefs, 180 briefs per month.

(A) Adult briefs are purchased only in accordance with the implementation of elimination guidelines developed by the Team.

(B) Exceptions to the requirement for implementation of elimination guidelines may be approved by the DDSD nurse when the ~~service recipient~~ member has a medical condition that precludes implementation

of elimination guidelines, such as atonic bladder, neurogenic bladder, or following a surgical procedure.

~~(c)~~ (d) **Exceptions.** Exceptions to the requirements of this Section are explained in this subsection.

(1) When a ~~service recipient's~~ member's Team determines that the ~~service recipient~~ member needs medical supplies that:

(A) are not available ~~under the Medicaid State Plan~~ through SoonerCare and for which no Health Care Procedure Code exists, the case manager e-mails pertinent information regarding the ~~service recipient's~~ member's medical supply need to the programs manager responsible for Specialized Medical Supplies. The e-mail includes all pertinent information that supports the need for the supply, including but not limited to, quantity and purpose; or

(B) exceed the limits stated in subsection ~~(b)~~ (c) of this Section, the case manager ~~submits the request for additional supplies to the DDSD area manager~~ documents the need in the Individual Plan for review and approval per 340:100-33.

(2) Approval or denial of exception requests is made on a case by case basis and does not override the general applicability of this Section.

(3) Approval of a specialized medical supplies exception does not exceed one plan of care year.

317:40-5-110. Authorization for Habilitation Training Specialist Services

(a) Habilitation Training Specialist (HTS) Services are:

(1) authorized as a result of needs identified by the team and informed selection by the ~~service recipient~~ SoonerCare member;

(2) shared among ~~service recipients~~ SoonerCare members who are members of the same household or being served in the same community location; ~~and~~

(3) authorized only during periods when staff are engaged in purposeful activity which directly or indirectly benefits the service recipient. Staff must be physically able and mentally alert to carry out the duties of the job. At no time are HTS services authorized for periods during which the staff are allowed to sleep~~.~~ ;

(4) not authorized to be provided in the home of the HTS unless the SoonerCare member and HTS reside in the same home; and

(5) directed toward the development or maintenance of a skill in order to achieve a specifically stated outcome. The service provided is not a function which the parent would provide for the individual without charge as a matter of course in the relationship among members of the nuclear family when the member resides in a family home.

(b) HTS Services may be provided in a group home as defined in 317:40-5-152 or community residential service settings defined in OAC 340:100-5-22.1 including:

(1) agency companion services as described in OAC 317:40-5-1 through 40-5-39;

(2) as provided in accordance with Daily Living Supports policy at OAC 317:40-5-150; and,

(3) as provided in accordance with Specialized Foster Care Policy at OAC 317:40-5-50 through 40-5-76; or

(4) services for people with Prader Willi syndrome.

(c) HTS Services are based on need and limited to no more than 12 hours per day per household in any setting other than settings described in OAC 340:100-5-22.1, Community Residential Supports, except with approval in accordance with OAC 340:100-3-33, Service authorization, that the increased services are necessary to avoid institutional placement due to:

(1) the complexity of the family or caregiver support needs. Consideration must be given to:

(A) the age and health of the caregiver;

(B) the number of household members requiring the caregiver's time; and

(C) the accessibility of needed resources; and

(2) the resources of the family, caregiver, or household members that are available to the service recipient. Consideration must be given to the number of family members able to assist the caregiver and available community supports; and

(3) the resources of other agencies or programs available to the ~~service recipient~~ SoonerCare member or family. Consideration must be given to services available from:

(A) the public schools;

(B) the Oklahoma Health Care Authority;

(C) the Oklahoma Department of Rehabilitative Services;

(D) other OKDHS programs; and

(E) services provided by other local, state, or federal resources.

(d) When it appears that approval of an exception is needed to prevent institutional placement, the case manager submits the request which identifies the circumstances supporting the need for an exception to the area manager.

(e) The DDSD area manager or designee must approve, deny, or notify the case manager of issues preventing approval within 10 working days.

(f) HTS providers may not perform any job duties associated with other employment, including on call duties, at the same time they are providing HTS services.

(g) HTS services are limited to no more than 40 hours per week when the HTS resides in the same home as the service recipient. If additional hours of service are needed, they must be provided by someone living outside the home.

(h) When the member is out of the home for school, work, adult day services or other non-HTS supported activities, the total number of hours of HTS and hours away from the home cannot exceed 12 hours per day unless an exception is granted in accordance with subsection c of this policy.

(i) In accordance with OAC 340:100-3-33.1, services must be provided in the most cost effective manner. When the need for HTS services is expected to continue to exceed 9 hours daily, cost effective community residential services must be considered and requested in accordance with OAC 317:40-1-2. For adults, continuation of non-residential services in excess of 9 hours per day for more than one plan of care year will not be authorized except:

(1) when needed for members who receive services through the Homeward Bound Waiver;

(2) when determined by the division administrator or designee to be the most cost effective option; or

(3) as a transition period of 120 days or less to allow for identification of and transition to a cost effective residential option. Members who do not wish to receive residential services will be assisted to identify options that meet their needs within an average of 9 hours daily.

317:40-5-111. Authorization for Habilitation Training Specialist Services in the Homeward Bound Waiver

(a) Habilitation Training Specialist (HTS) Services are authorized as a result of needs identified by the Personal Support Team and informed service recipient selection.

(b) HTS Services may be provided in the Homeward Bound waiver in service settings including:

(1) agency companion services as described in OAC 317:40-5-1 through OAC 317:40-5-39;
(2) daily living supports as described in OAC 317:40-5-153;
(3) specialized foster care as described in OAC 317:40-5-50 through OAC 317:40-5-76;
(4) group home services as described in OAC ~~340:100-6~~ 317:40-5-152; and
(5) the class member's own home, family's home, or other community residential setting.

(c) HTS services are authorized only during periods when staff are engaged in purposeful activity that directly or indirectly benefits the person receiving services.
(1) Staff must be physically able and mentally alert to carry out the duties of the job.
(2) At no time are HTS services authorized for periods during which the staff are allowed to sleep.

317:40-5-113. Adult Day Services

(a) **Introduction.** Adult Day Services are provided by agencies approved by the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS) that have a valid Oklahoma Health Care Authority contract for providing Adult Day Services. This service is available through the Community Waiver and through the In-Home Supports Waiver for Adults. Adult Day Services is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective environment for some portion of a day. Individuals who participate in adult day services receive these services on a planned basis during specified hours. Adult day services are designed to work toward the goals of:
(1) promoting the ~~individual's~~ member's maximum level of independence;
(2) maintaining the ~~individual's~~ member's present level of functioning as long as possible, preventing or delaying further deterioration;
(3) assisting the ~~individual~~ member in achieving the highest level of functioning possible;
(4) providing support, respite, and education for families and other caregivers; and
(5) fostering socialization and peer interaction.

(b) **Eligibility requirements.** Adult Day Services are provided to eligible ~~service recipients~~ members whose teams have determined the service is appropriate to meet their needs. ~~Service recipients~~ Members must:
(1) require ongoing support and supervision in a safe environment when away from their own residence;
(2) be 18 years of age or older; and
(3) not pose a threat to others.

(c) **Provider requirements.** Provider agencies must:
(1) meet the licensing requirements set forth by Section 1-873 et seq of Title 63 of the Oklahoma Statutes;
(2) comply with OAC 310:605, Adult Day Care Centers;
(3) allow DDSD staff to make announced ~~or~~ and unannounced visits to the facility during the hours of operation;
(4) provide the DDSD ~~Case Manager~~ case manager a copy of the individualized plan of care; ~~and~~
(5) submit incident reports ~~in accordance with~~ per OAC 340:100-3-34~~.~~ ;
(6) maintain a copy of the member's Individual Plan (Plan);
(7) submit Oklahoma Department of Human Services (OKDHS) Adult Day Services Progress Report Form 06WP046E to the DDSD case manager by the

tenth of each month for the previous month's services, for each member receiving services; and

(8) serve as a member of the Personal Support Team and meet the Personal Support Team requirements per OAC 340:100-5-52.

(d) **Coverage.** The ~~service recipient's~~ member's ~~Individual Plan (IP)~~ Plan contains detailed descriptions of services to be provided and documentation of hours of services. All services must be authorized in the ~~IP~~ Plan and reflected in the approved plan of care. Arrangements for care must be made with the ~~service recipient's~~ member's case manager.

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-150. Daily Living Supports for the Community Waiver

(a) **Introduction.** Daily Living Supports (DLS) are provided by an agency, approved by the Developmental Disabilities Services Division (DDSD), that has a valid Oklahoma Health Care Authority contract for the service.

(1) Daily Living Supports require meeting the daily support needs of the ~~service recipients~~ members living in the home.

(A) In accordance with the needs of the ~~service recipient~~ member, Daily Living Supports include hands-on assistance, supervision, or prompting so that the ~~service recipient~~ member performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports also include assistance with cognitive tasks or provision of services, ~~in accordance with~~ per OAC 340:100-5-57, to prevent a ~~service recipient~~ member from harming self or others.

(C) Daily Living Supports also include:

(i) the provision of staff training ~~in accordance with~~ per OAC 340:100-3-38, to meet the specific needs of the ~~service recipient~~ member;

(ii) program supervision that includes the 24-hour availability of response staff to meet schedules and unpredictable needs;

(iii) program oversight;

(iv) assisting the ~~service recipient~~ member in obtaining services and supplies;

(v) developing and assuring emergency plans are in place; and

(vi) coordinating overall safety and supports in the home.

(D) Direct support services are coordinated and shared among household members receiving services to meet identified needs and are provided by staff who do not live in the home.

(2) DLS include an average of eight hours daily of direct support services. ~~Service recipients~~ Members needing direct support services exceeding an average of eight hours per day identify, with case manager assistance, roommates willing to share Daily Living Supports services. Additional direct support services are considered in accordance with subsection (f) of this Section.

(b) **Eligibility.** Daily Living Supports are provided to ~~individuals~~ members who:

(1) are eighteen years of age or older, unless approved by the Director of OKDHS or designee;

(2) need an average of at least eight hours of direct support services daily;

(3) are participants in the DDSD Community waiver, ~~described in~~ per OAC 317:40-1-1;

(4) need community residential services outside the family home; and

(5) do not simultaneously receive any other community residential or group home services.

(c) **Service requirements.** Daily Living Supports must be:

(1) included in the ~~service recipient's~~ member's Individual Plan ~~in accordance with~~ per OAC 340:100-5-51, including a description of the type(s) and intensity of supervision and assistance that must be provided to the ~~service recipient~~ member;

(2) authorized in the ~~service recipient's~~ member's Plan of Care;

(3) provided by the contracted provider agency chosen by the ~~service recipient~~ member or guardian;

(4) delivered in accordance with DDSD Community Residential Supports rules at OAC 340:100-5-22.1; and

(5) provided directly to the ~~service recipient~~ member.

(d) **Home Requirements.** Daily Living Supports are provided to eligible ~~service recipients~~ members living outside their family's home in a home that:

(1) is leased or owned by the ~~service recipient(s)~~ member(s) or the ~~service recipient's~~ member's legal guardian; and

(2) houses no more than three individuals living together. Exceptions for homes shared by four ~~service recipients~~ members may be granted in writing by the DDSD director or designee.

(e) **Responsibilities of provider agencies.** Each provider agency providing Daily Living Supports must:

(1) ensure ongoing supports as needed when the ~~service recipient~~ member is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;

(2) ensure compliance with all applicable DDSD policy found at OAC 340:100; and

(3) provide for the welfare of all ~~service recipients~~ members living in the home.

(4) ensure that trained staff are available to the member as described in the individual plan.

(f) **Criteria for direct support staff services beyond eight hours per day.** Additional direct support services including Habilitation Training Specialist(HTS), Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section must be approved by the DDSD area manager or designee.

(1) In order to receive additional direct support staff services, the ~~service recipients~~ members living together must have insufficient supports including hourly nursing services to meet their needs for support.

(A) Additional direct support staffing may be authorized if the ~~service recipient~~ member is living with two roommates but still has medical or behavior support needs beyond the capacity of staff shared with the other roommates, including participation by staff providing hourly nursing services.

(B) Additional direct support staffing is only provided to a ~~service recipient~~ member who has one or no roommates if:

(i) the area manager or designee documents that behavior support issues make it impossible for the ~~service recipient~~ member to have a roommate; or

(ii) in accordance with paragraph (2) of this subsection.

(C) If a ~~service recipient~~ member lives with one or no roommates or requires a second support staff to meet his or her intensive behavior support needs, the Team must provide clear documentation that the ~~service recipient~~ member has difficulty establishing compatible relations with others as evidenced by:

(i) severe and persistent emotional and behavioral disturbances; or

(ii) a history of difficulty sharing a home with others.

(2) The area manager or designee may grant conditional approvals for staff beyond an average of eight hours per day per ~~service recipient~~ member:

(A) due to the temporary or permanent departure of a roommate while another roommate is being identified; or

(B) to facilitate emergency residential placement of a person needing services while roommates are being identified.

(3) As part of the annual review, the case manager must:

(A) re-evaluate the ~~service recipient's~~ member's additional direct support services; and

(B) implement any alternative solutions that would promote independence and reduce intrusion by paid workers as much as possible. Documentation of such evaluations and the implementation of alternative solutions is included in the case manager's record.

(g) **Daily Living Supports claims.** No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each ~~service recipient~~ member.

(1) The provider agency claims one unit of service for each day during which the ~~service recipient~~ member receives Daily Living Supports. A day is defined as the period between 12:00 a.m. and 11:59 p.m.

(2) Claims must not be based on budgeted amounts.

(3) When a ~~service recipient~~ member changes provider agencies, only the outgoing service provider agency claims for the day that the ~~service recipient~~ member moves.

(h) **Billing for other support services.** Additional support services such as HTS, Intensive Personal Supports, or Homemaker Services may be provided to a ~~service recipient~~ member receiving Daily Living Supports, if:

(1) the additional support services have been authorized in the ~~service recipient's~~ member's Plan of Care. Additional support services cannot be authorized unless 56 hours per week of DLS services are scheduled for the ~~service recipient~~ member. The direct support staffing is averaged across the week when the needs of the ~~service recipients~~ members in the household vary from day to day; and

(2) an average of eight hours of DLS has already been provided to the ~~service recipient~~ member each day that week.

(A) The provider cannot bill for additional support services unless 56 hours of DLS have been provided during the week to the ~~service recipient~~ member.

(B) If support services are provided to multiple ~~service recipients~~ members residing in the same household at the same time, the provider agency cannot count these hours toward each ~~service recipient's~~ member's 8-hour minimum. For example, three hours of service provided simultaneously by a single direct contact staff to three ~~residents~~ members in the same household may only be counted as three hours of service for one of the ~~service recipients~~ members, not three hours for each ~~resident~~ member.

(i) **Therapeutic leave.** Therapeutic leave is a ~~Medicaid~~ SoonerCare payment made to the Daily Living Supports contract provider to enable the ~~service recipient~~ member to retain personal care services.

(1) Therapeutic leave is claimed when the ~~service recipient~~ member does not receive Daily Living Supports services for 24 consecutive hours from 12:00 a.m. to 11:59 p.m. because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. Daily living supports staff ~~are~~ may be present with the ~~service~~

~~recipient~~ member in the hospital as approved by the ~~service recipient's~~ member's Team in the Individual Plan. Staff are present in the role of a visitor and are not responsible for the care of the patient.

(2) A ~~service recipient~~ member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) To promote continuity of direct support staff in the ~~service recipient's~~ member's absence, the provider pays the staff member the salary that he or she would have earned if the ~~service recipient~~ member were not on therapeutic leave if the provider is unable to provide an alternative work opportunity.

317:40-5-152. Group home services for persons with mental retardation or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to 24-hour per day supervision, supportive assistance, and training in daily living skills to persons who are eligible 18 years of age or older. Upon approval of the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) director or designee, persons younger than 18 may be served.

(1) Group homes ensure members reside and participate in the community. Services are provided in homes located in close proximity to generic community services and activities.

(2) Group homes must be licensed by DDSD in accordance with Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

(3) Residents of group homes receive no other form of residential supports.

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may be approved only by the DDSD director or designee to resolve a temporary emergency when no other resolution exists, or in a community living group home when the needs are so extensive that additional supports are needed for specific activities at identified times and the resulting plan of care is the most cost effective option. A weekly average of eight hours per day of direct contact staff must be provided per resident receiving community living group home services before HTS services may be claimed.

(b) **Minimum provider qualifications.** Approved providers must have a current ~~contract~~ provider agreement with the Oklahoma Health Care Authority (OHCA) to provide DDSD Home and Community-Based Services (HCBS) ~~Waiver~~ for persons with mental retardation or related conditions.

(1) Group home providers must have a completed and approved application to provide DDSD group home services.

(2) Group home staff must:

(A) complete the OKDHS DDSD-sanctioned training curriculum per OAC 340:100-3-38; and

(B) fulfill requirements for pre-employment screening per OAC 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

(A) meet all applicable requirements of OAC 340:100; and

(B) are provided in accordance with each member's Individual Plan (IP) developed per OAC 340:100-5-50 through 340:100-5-58.

(i) Health care services are secured for each member per OAC 340:100-5-26.

(ii) Members are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.

(2) Group home providers:

(A) follow protective intervention practices per OAC 340:100-5-57 and 340:100-5-58;

(B) in addition to the documentation required per OAC 340:100-3-40, must maintain:

(i) staff time sheets that document the hours each staff was present and on duty in the group home; and

(ii) documentation of each member's presence or absence on ~~the~~ a daily attendance form ~~provided by DDSD~~; and

(C) ensure program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services per OAC 340:100-5-22.6 and 340:100-6, as applicable.

(d) **Coverage limitations.** Group home services are provided up to 366 days per year.

(e) **Types of group home services.** There are three types of group home services provided through HCBS Waivers.

(1) **Traditional group homes.** Traditional group homes serve no more than 12 members per OAC 340:100-6.

(2) **Community living homes.** Community living homes serve no more than 12 members.

(A) Members who receive community living home services ~~have~~:

(i) have needs that cannot be met in a less structured setting; and

~~(ii) a diagnosis of severe or profound mental retardation requiring frequent assistance in the performance of activities necessary for daily living or continual supervision to ensure the member's health and safety; or~~

(ii) require regular, frequent, and sometimes constant assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;

~~(iii) complex needs requiring frequent:~~

~~(I) assistance in the performance of activities necessary for daily living, such as frequent assistance of staff for positioning, bathing, or other necessary movement;~~ or

~~(II)~~(iii) require supervision and training in appropriate social and interactive skills, due to on-going behavioral issues ~~in order~~ to remain included in the community.

(B) Services offered in a community living home include:

(i) 24-hour awake supervision when a member's IP indicates it is necessary; and

(ii) program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.

(C) Services may be approved for individuals in a traditional group home at the community living service rate if the member has had a change in health status or behavior and meets requirements to receive community living home services. Requests to receive community living home services are sent to the DDSD Community Services Residential Unit.

(3) **Alternative group homes.** Alternative group homes serve no more than four members who have evidence of behavioral or emotional challenges in addition to mental retardation and require extensive supervision and assistance in order to remain in the community.

(A) Members who receive alternative group home services must meet criteria per in OAC 340:100-5-22.6.

(B) A determination must be made by the DDSD Community Services Unit that alternative group home services are appropriate.

317:40-5-153. Daily Living Supports for the Homeward Bound Waiver

(a) **Introduction.** Daily Living Supports are provided by an agency with a valid ~~OHCA~~ Oklahoma Health Care Authority (OHCA) contract~~, approved by DDSD, for the service~~.

(1) Daily Living Supports require meeting the daily support needs of the ~~people~~ member living in the home.

(A) In accordance with the needs of the class member, Daily Living Supports include hands-on assistance, supervision, or prompting so that the ~~person~~ member performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports are provided by staff that do not live in the home ~~also~~ and include assistance with cognitive tasks or provision of services to prevent ~~an individual~~ a member from harming self or others, in accordance with the needs of the ~~person receiving services~~ member.

(C) Daily Living Supports also include:

(i) the provision of staff training per OAC 340:100-3-30 to meet the specific needs of the ~~service recipient~~ member;

(ii) program supervision that includes 24-hour availability of response staff to meet schedules and unpredictable needs; ~~and~~

(iii) program oversight~~.~~;

(iv) assisting the member in obtaining services and supplies;

(v) developing and assuring emergency plans are in place;

(vi) coordinating overall safety and supports in the home; and

(vii) assisting members with personal money management.

(2) Daily Living Supports are used to provide and fund up to eight hours per day of supports for class members receiving supported living services ~~as detailed in~~ per OAC 340:100-5-22.5.

(b) **Eligibility.** Daily Living Supports, as described in this Section, are provided to ~~individuals~~ members who:

(1) are members of the class certified in Case Number 85-C-437-E, U.S. District Court for the Northern District of Oklahoma;

(2) receive community residential services in their own home; and

(3) do not simultaneously receive any other community residential or group home services.

(c) **Responsibilities of provider agencies.** Each provider agency providing Daily Living Supports must:

(1) ensure ongoing supports as needed to all ~~service recipients~~ members living in the home when one or more ~~service recipients~~ members is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;

(2) ensure compliance with all applicable DDSD policy found at OAC 340:100; ~~and~~

(3) provide for the welfare of all ~~service recipients~~ members living in the home~~.~~ ; and

(4) ensure that trained staff are available as described in the member's individual plan.

(d) **Criteria for direct support staff services in the Homeward Bound Waiver beyond eight hours per day.** Additional direct support services including HTS, Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section, are provided based on

needs identified by the Personal Support Team and are considered in accordance with subsection (f) of this Section.

(e) **Daily Living Supports claims.** No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each ~~individual receiving services~~ member.

(1) The provider agency claims one unit of service for each day the ~~individual~~ member receives Daily Living Supports.

(2) Providers must claim at least monthly for all days that Daily Living Supports were actually provided during the preceding month. Claims must not be based on budgeted amounts.

(3) When ~~an individual~~ a member changes provider agencies, only the outgoing service provider agency claims for the day that the ~~individual~~ member moves.

(f) **Billing for other support services.** ~~The provider agency may claim separately for additional support services such as HTS, Intensive Personal Supports, or Homemaker Services provided to an individual~~ Additional support services such as HTS, Intensive Personal Supports, or Homemaker Service may be provided to a member receiving Daily Living Supports, if:

(1) additional support services have been authorized in the ~~person's~~ member's Plan of Care. Additional support services cannot be authorized unless 56 hours per week of DLS services are scheduled for the member. The direct support staffing is averaged across the week when the needs of the members in the household vary from day to day; and

(2) an average of eight hours ~~of direct staff support, excluding Nursing, have already been provided to the person that day.~~ of DLS has already been provided to the member each day that week. ~~If support services are provided to multiple individuals residing in the same household at the same time, the provider agency cannot count these hours toward each individual's eight-hour minimum. For example, three hours of HTS provided simultaneously by a single direct contact staff to three residents in the same household may only be counted as three hours of HTS for one of the individuals, not three hours for each resident.~~

(g) **Therapeutic leave.** Therapeutic leave is a Medicaid payment made to the Daily Living Supports contract provider to enable the ~~service recipient~~ member to retain direct support services.

(1) Therapeutic leave is claimed when the ~~service recipient~~ member does not receive Daily Living Supports services for 24 consecutive hours because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. Daily living supports staff ~~are~~ may be present with the ~~individual~~ member in the hospital as approved by the ~~person's~~ member's Team in the Individual Plan. Staff are present in the role of a visitor and are not responsible for the care of the patient.

(2) ~~An individual~~ A member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) If, because of the ~~service recipient's~~ member's absence, the direct support staff ~~member~~ is unable to work, the provider pays the staff ~~member~~ the salary that he or she would have earned if the ~~service recipient~~ member were not on therapeutic leave.

317:40-7-12. Enhanced rates

An Enhanced Rate is available for both Community-Based Group Services and Group Job Coaching Services~~.~~ when necessary to meet a member's intensive personal needs in the employment setting(s). The need for the enhanced rate is identified through the Team process and is supported by documentation in the Individual Plan (Plan) with consideration of risk assessment per OAC 340:100-5-56 and assessment of medical, nutritional, and mobility needs and:

(1) ~~Eligibility for an enhanced rate is determined by~~ Team assessment ~~as detailed in~~ per OAC 340:100-5-51, OAC 340:100-5-56, OAC 340:100-5-57, and ~~subsection (d) of~~ OAC 340:100-5-26 of the ~~service recipient's~~ member's needs.

(2) ~~To be eligible for the enhanced rate,~~ the ~~service recipient~~ member must:

(A) have a protective intervention plan that:

(i) contains a restrictive or intrusive procedure as defined in OAC 340:100-1-2 implemented in the employment setting;

(ii) has been approved by the State Behavior Review Committee (SBRC) in accordance with OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff ~~in accordance with subsection (g) of~~ per OAC 340:100-5-57; and

(iii) has been reviewed by the Human Rights Committee (HRC) ~~in accordance with~~ per OAC 340:100-3-6;

(B) have procedures included in the Individual Plan which address dangerous behavior that places the ~~service recipient~~ member or others at risk of serious physical harm but are neither restrictive or intrusive procedures as defined in OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to assure that positive approaches are being used to manage dangerous behavior;

(C) have a visual impairment that requires assistance for mobility or safety;

(D) have two or more of the circumstances given in this subparagraph.

(i) The ~~service recipient~~ member has medical support needs which are rated at Level 4, Level 5, or Level 6 on the Physical Status Review (PSR), explained in OAC 340:100-5-26 or a comparable level of high medical needs as documented in the Plan.

(ii) The ~~service recipient~~ member has nutritional needs ~~supported by the PSR~~ requiring tube feeding or other dependency for food intake which must occur in the employment setting.

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in OAC 317:40-7 are:

(1) approved in accordance with OAC 317:40-7-21 prior to service implementation;

(2) intended to result in the Personal Support Team (Team) development of an employment plan tailored to meet the member's needs;

(3) identified in the Individual Plan ~~(IP)~~ (Plan) process per OAC 340:100-5-50 through 340:100-5-58; and

(4) documented and recorded on Oklahoma Department of Human Services (OKDHS) Form 06WP047E, Exception Request for Waiver Employment Services, by the Developmental Disabilities Services Division (DDSD) case manager after Team approval.

(b) A request for an exception to the minimum of 30 hours per week of employment services, adult day services per OAC 317:40-5-113, or a

combination of both, per OAC 317:40-7-15, includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans;

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and

(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.

(c) A request for an exception to the maximum limit of 15 hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(d) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(e) Within ten working days of the annual ~~IP~~ Individual Planning or interim meeting, the DDSD case manager sends OKDHS Form 06WP047E to area employment services staff, who reviews the form to ensure all criteria per OAC 317:40-7-21 are met. If criteria are:

(1) not met, employment services staff returns OKDHS Form 06WP047E with recommendations to the DDSD case management supervisor and case manager for resubmission; or

(2) met, employment services staff returns OKDHS Form 06WP047E to the case management supervisor to resume the approval process and input of units on the member's Plan of Care.

(f) Exception requests per OAC 340:40-7-21(f) are documented by the DDSD case manager after Team consensus and submitted via OKDHS Form 06WP047E to the DDSD area manager within ten working days after the annual IP or interim Team meeting. The area manager approves or denies the request with a copy to the DDSD area office claims staff and case manager based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives.

(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:

(A) Team's discussion of current specific situation that requires an exception;

(B) specific medical issues necessitating the exception request; and

(C) a projection of units needed to complete the State fiscal year.

(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans.

(g) The DDSD director or designee may review exceptions granted ~~in accordance with~~ per OAC 317:40-7-21, directing the Team to provide additional information, if necessary, to comply with OAC 340:100-3-33.1 and other applicable rules.

(iii) The ~~service recipient~~ member has mobility needs, ~~supported by the PSR,~~ such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology has been evaluated for the current employment program and determined not feasible by the DDSD division director or designee; or

(E) reside in alternative group home as described in OAC 317:40-5-152.

(3) The enhanced rate can be claimed only if the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38.

(4) There are no exceptions for the enhanced rate other than as allowed in this Section.

Recommendation (a): Prior Authorize Atypical Antipsychotics

The Drug Utilization Review Board recommends the addition of the Atypical Antipsychotics class to the Product Based Prior Authorization program. The following Tier lists have been reviewed and determined to be an acceptable combination for use as initial therapy for the majority of members. The DUR Board recommends this list to the OHCA Board of Directors based on cost and clinical effectiveness for approval. The following are the recommendations for this category:

- Children less than 5 years of age will require a "second opinion" prior authorization to be reviewed by an OHCA-contracted child psychiatrist. Current users will be allowed to remain on current medication until the petition is submitted and reviewed. See Appendix 1 for second opinion process.
- For all members on atypical antipsychotics, after six months of use, a questionnaire will be sent to the prescriber to be filled out and returned for continuation of therapy. See Appendix 2 for suggested process for questionnaires.
- Requests for unusual dosing or indications will be referred to the OHCA-contracted psychiatrist for review.
- In addition, the College recommends the following tier structure and approval criteria:

Atypical Antipsychotics*

Tier 1	Tier 2	Tier 3†
risperidone (Risperdal®)₮ **clozapine (Clozaril®)**	Supplemental Rebated Tier-3 medications	olanzapine (Zyprexa®) quetiapine (Seroquel®) ziprasidone (Geodon®) aripiprazole (Abilify®) paliperidone (Invega®) quetiapine ER (Seroquel XR®) asenapine (Saphris®) clozapine (Fazaclo®) olanzapine/fluoxetine (Symbyax®) iloperidone (Fanapt™)

*Mandatory Generic Plan Applies †May be rebated to Tier 2 status only ₮Includes Risperdal Consta

Approval Criteria for Tier 2 Medication:

1. Current users/inpatient discharge:
    a. Members currently stabilized on a higher tiered medication defined by paid claim(s) for the higher tiered medication in the past 90 days will be approved.
    b. Members being released from a hospital and stabilized on a higher tier medication will be approved.
2. Clinical conditions:
    a. Approvals will be granted for members with clinical conditions for which lower tiered drugs are contraindicated.
    b. Approvals will be granted for members whose current regimen includes drugs known to adversely interact with all lowered tiered drugs.

3. Step therapy:
    a. A trial of risperidone, at least 14 days in duration, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects.

Approval Criteria for Tier 3 Medication:

1. Current users/inpatient discharge:
    a. Members currently stabilized on a higher tiered medication defined by paid claim(s) for the higher tiered medication in the past 90 days will be approved.
    b. Members being released from a hospital and stabilized on a higher tier medication will be approved.
2. Clinical conditions:
    a. Approvals will be granted for members with clinical conditions for which lower tiered drugs are contraindicated.
    b. Approvals will be granted for members whose current regimen includes drugs known to adversely interact with all lowered tiered drugs.
3. Step therapy:
    a. A trial of risperidone, at least 14 days in duration, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects.
    b. A trial of all available Tier 2 medications, at least 14 days in duration, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects.
    c. For aripiprazole and quetiapine: a diagnosis of depression requires current use of an antidepressant, and previous trials with at least two other antidepressants.

Recommendation (b): Prior Authorize Ribavirin Solution and Dose Packs

The DUR Board recommends placing a prior authorization on Ribavirin suspension and dose packs. Approval would be based on clinical supporting information regarding the inability of member to swallow, hypersensitivity, medical reasons why member cannot take tablet formulation, or for use in children 3 to 10 years of age (suspension only). *The DUR Board voted to include Ribavirin capsules in this prior authorization, but recently the generic capsule price has dropped to the level of the generic tablets. Due to these market circumstances, OHCA Staff recommend the PA only for the solution and convenience dose packs.