

OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
December 9, 2010
College of Osteopathic Medicine
1111 W. 17th, 4th Floor Conference Rm.
Tulsa, 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 November 18, 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 - Garth Splinter, M.D.
 - c) Oklahoma Electronic Health Records Incentive Program Update
Adolph Maren, Senior Planning Coordinator
 - d) Policy Making Process - Cindy Roberts, Deputy CEO

Item to be presented by Chairman Roggow

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

Item to be presented by Howard Pallotta, Director of Legal Services

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

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

6. 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 **the Emergency Rules** in accordance with 75 Okla. Stat. § 253
 - b) Consideration and Vote Upon promulgation of **Emergency Rules** as follows:
 - 6.b-1 AMENDING Agency rules at OAC 317:30-5-42.16 and 30-5-532 to allow hospice services to be available to children eligible for SoonerCare without forgoing any other service for treatment of the underlying terminal conditions. Families are no longer required to elect hospice services in lieu of standard SoonerCare services that have the objective to treat or cure the terminal illness. Additional revisions include allowing nurse practitioners to recertify the continuation of hospice services. The revisions ensure Agency compliance with Public Laws 111-148 and 111-152.

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

6.b-2 AMENDING Agency rules at OAC 317:50-1-14, 50-3-14 and 50-5-14 to include a requirement for re-evaluation of members receiving hospice services in the HCBS Waivers. ADvantage, Medically Fragile, My Life, My Choice and Sooner Seniors HCBS waivers currently have no set authorization limits for hospice care, allowing members to receive hospice services for an unlimited period of time. Rules are revised to include a re-authorization process after the initial six months of hospice care. A re-evaluation of the member will be performed and additional hospice care authorized for a period not to exceed 60 days. A re-evaluation will be performed every 60 days as needed. The revisions ensure Agency compliance with Public Laws 111-148 and 111-152.

Item to be presented by Chairman Roggow

7. 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)and(7)

A. Status of Pending Suits

1. Assoc. for Direct Care Trainers v. OHCA	CJ-08-4237 (Okla.County)
2. Covalt v. OKDHS	CJ-08-85 (Grant County)
3. Wright v. OHCA	CJ-09-3924 (Okla.County)
4. Moss v. Wittmer	108,355 (Okla. S. Ct.)
5. Peak Medical v. Sebelius	10 CV-597 TCKPJC(Northern District)
6. U.S. v. Wyeth	03-12366-DPW and 06-11724-DPW(District of Massachusetts)
7. OHCA v. Merck	5:09-cv-01018-R(Western District)
8. State of Oklahoma (Edmondson) v. Abbott Laboratories	CJ-10-474 (Pottawatomie County)

B. Discussion of C.E.O. Fogarty's Employment/Work Performance

8. New Business

9. **ADJOURNMENT**

NEXT BOARD MEETING
January 13, 2011
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
November 18, 2010
Held at Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
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 November 16, 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 1:02PM.

BOARD MEMBERS PRESENT:

Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow

BOARD MEMBERS ABSENT:

Member McVay

OTHERS PRESENT:

Anne Anthony, Willow Crest
Brent Willborn, OKPCA
Josh Cook, HP
Shari Murphree, Willow Crest
Justin Martino, eCapitol
Judy Goforth Parker, Chickasaw Nation

OTHERS PRESENT:

Steven Goodman, Willow Crest
Charles Brodt, HP
April Wilkerson, Journal Record
Dena Thayer, OKDHS
Laura Box, Positive Changes

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD OCTOBER 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 October 14, 2010 board minutes as presented. Member Langenkamp seconded.

FOR THE MOTION:

Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, and Chairman Roggow

ABSTAIN:

Member McFall

BOARD MEMBER ABSENT:

Member McVay

PRESENTATION OF ALL STAR EMPLOYEES

Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez presented Heather Stafford, November All Star Employee; Stephen Weiss; December All Star Employee; and Kyle Janzen, Supervisor of the Quarter. Mr. Gomez recognized the newly appointed Oklahoma Health Information Technology(OHIT)Coordinator for the State, John Calabro.

FINANCIAL UPDATE

Carrie Evans, Chief Financial Officer

Ms. Evans stated that the revenues for OHCA Revenues for OHCA through September, accounting for receivables, were **\$1,048,332,388** or **(1.4%) under** budget. The expenditures for OHCA, accounting for encumbrances, were **\$818,084,286** or **3.1% under** budget. She noted the state dollar budget variance through September is **\$11,406,300 positive**. The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	.6
Administration	1.2
Revenues:	
Taxes and Fees	.3
Drug Rebate	(.1)
Overpayments/Settlements	0
Total FY 10 Variance	\$ 2.0

MEDICAID DIRECTOR'S UPDATE

Garth Splinter, MD

Dr. Splinter presented the SoonerCare Programs September 2010 Data which shows an increase of 3300 from last month, bringing the total monthly enrollment number to 743,760 members. He also presented the historic average SoonerCare enrollment per month; and the SoonerCare monthly total enrollment compared to net enrollment change. Dr. Splinter noted that there will be changes coming on the OLL Waiver Flow chart adding dollar and number amounts. See Item 4b for detailed report.

Mr. Gomez discussed the OSMA handouts in the board packet regarding quality of care. He stated that while attending the National Association of State Medicaid Directors last week in Washington there was a lot of interest expressed concerning the best practices in Oklahoma. Other areas of continued interest were Medical Home, Insure Oklahoma, and Program Integrity. Mr. Gomez noted that the annual report is in the board packet and copies available for the public. The annual report is also available online.

ITEM 5/PRESENTATION OF THE TOBACCO SETTLEMENT ENDOWMENT TRUST(TSET)COLLABORATIVE PROGRAM

Terrie Fritz, External Relations Coordinator

Ms. Fritz reported on the SoonerQuit Women Campaign for the tobacco cessation program which is a collaborative with the Tobacco Settlement Endowment Trust, the Health Department and OHCA. Ms. Fritz introduced Sonnja Paulson with the Tobacco Settlement Endowment Trust and Shelly Patterson who are both involved on this project. She discussed the Phase 1 which consists of a recruitment campaign to recruit potential real life women who have quit smoking in the last 1-3 years who are between the ages of 20 and 36 with diverse ethnicity. Ms. Fritz discussed Phase 2 which consists of the media campaign of the 6 stories that will be selected and will be featured in a statewide media campaign targeted at women age 18-49 of low socioeconomic status. The recruitment ads were played for the board members and public attendees. This will be a statewide campaign.

ITEM 6/REPORTS TO THE BOARD BY BOARD COMMITTEES

Chairman Roggow

Audit/Finance Committee

Member Miller

Member Miller reported that the Audit/Finance Committee met and discussed with Juarez McCann the budget request for FY2012. Member Miller reported that the stimulus money and the claw-back credit will no longer be available and our FMAP federal match will be lower. He noted that the current financial report is encouraging.

ITEM 7/PRESENTATION OF THE STATE FISCAL YEAR 2012 BUDGET REQUEST

Juarez McCann, Chief Budget Officer

Mr. McCann discussed 28 items of detailed priority and stated that the total budget request for FY 2012 was \$467 million with an additional \$75-80 million needed. For detailed description of priorities see Item 7 of the board packet.

ITEM 8 - ANNOUNCEMENTS 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 and found there were no conflicts regarding Items 9, 10, and 12 of the board agenda.

ITEM 9.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 emergency as presented. Member Langenkamp seconded.

FOR THE MOTION:

Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

BOARD MEMBER ABSENT:

Member McVay

ITEM 9.b) CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:

Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts presented Rule 9.b-1 as published on agenda.

MOTION:

Member McFall moved for approval of 9.b-1 as presented. Member Bryant seconded.

FOR THE MOTION:

Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

BOARD MEMBER ABSENT:

Member McVay

ITEM 8/CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE

Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts presented the rates as published on agenda. For full details of the rates see Item 10a, and 10b of the board packet.

10a) Consideration and Vote Upon rate proposal by OHCA to rescind the tiered reimbursement methodology approved by the board on March 11, 2010.

10b) Consideration and Vote Upon rate proposal to reimburse residential treatment service providers 100% of the base per diem rate in effect April 1, 2010 for each authorized date of service.

MOTION:

Member Bryant moved for approval of Item 10a and 10b as presented. Member McFall seconded

FOR THE MOTION:

Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

BOARD MEMBER ABSENT:

Member McVay

ITEM 11- 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, General Counsel

MOTION: Member McFall moved for executive session. Member Bryant seconded.

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

BOARD MEMBER ABSENT: Member McVay

ITEM 12 - CONSIDERATION AND VOTE UPON BOARD MEETINGS DATES, TIMES, AND PLACES FOR THE OKLAHOMA HEALTH CARE AUTHORITY BOARD FOR CALENDAR YEAR 2011.

MOTION: Vice Chairman Armstrong moved for approval of the 2011 OHCA Board Calendar. Member McFall seconded.

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

BOARD MEMBER ABSENT: Member McVay

NEW BUSINESS:

None

ADJOURNMENT

MOTION: Member McFall move for adjournment. Member Langenkamp seconded. Member McFall seconded.

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

BOARD MEMBER ABSENT: Member McVay



FINANCIAL REPORT

For the Four Months Ended October 31, 2010
 Submitted to the CEO & Board
 December 9, 2010

- Revenues for OHCA through October, accounting for receivables, were **\$1,287,754,541** or **(1.3%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **\$1,073,131,372** or **2.8% under** budget.
- The state dollar budget variance through October is **\$14,676,824 positive**.
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance	8.9	
Administration	1.3	
Revenues:		
Taxes and Fees	1.5	
Drug Rebate	2.0	
Overpayments/Settlements	1.0	
Total FY 10 Variance	\$ 14.7	

ATTACHMENTS

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Fund 255: OHCA Medicaid Program Fund	7

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2011, for the Four Months Ended October 31, 2010

REVENUES	FY11 Budget YTD	FY11 Actual YTD	Variance	% Over/ (Under)
State Appropriations	\$ 377,665,522	\$ 377,665,522	\$ -	0.0%
Federal Funds	657,176,088	630,428,412	(26,747,676)	(4.1)%
Tobacco Tax Collections	18,836,241	19,351,409	515,168	2.7%
Quality of Care Collections	16,818,735	17,826,949	1,008,214	6.0%
Prior Year Carryover	45,663,786	45,663,786	-	0.0%
Federal Deferral - Interest	33,343	33,343	-	0.0%
Drug Rebates	62,552,422	68,128,168	5,575,746	8.9%
Medical Refunds	16,010,765	18,850,248	2,839,483	17.7%
Other Revenues	5,423,853	5,436,835	12,982	0.2%
Stimulus Funds Drawn	104,369,869	104,369,869	-	0.0%
TOTAL REVENUES	\$ 1,304,550,624	\$ 1,287,754,541	\$ (16,796,083)	(1.3)%

EXPENDITURES	FY11 Budget YTD	FY11 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	\$ 14,582,995	\$ 11,967,309	\$ 2,615,686	17.9%
ADMINISTRATION - CONTRACTS	\$ 39,694,210	\$ 38,792,564	\$ 901,646	2.3%
MEDICAID PROGRAMS				
<u>Managed Care:</u>				
SoonerCare Choice	9,866,808	8,769,958	1,096,849	11.1%
<u>Acute Fee for Service Payments:</u>				
Hospital Services	295,353,862	287,018,096	8,335,766	2.8%
Behavioral Health	91,762,549	90,549,082	1,213,467	1.3%
Physicians	139,430,050	130,172,533	9,257,518	6.6%
Dentists	52,704,829	49,653,384	3,051,445	5.8%
Other Practitioners	18,136,492	19,694,922	(1,558,430)	(8.6)%
Home Health Care	6,976,228	7,317,239	(341,011)	(4.9)%
Lab & Radiology	15,638,909	15,866,388	(227,479)	(1.5)%
Medical Supplies	16,545,202	15,003,191	1,542,011	9.3%
Ambulatory Clinics	28,538,200	26,692,397	1,845,803	6.5%
Prescription Drugs	113,846,672	107,027,556	6,819,116	6.0%
Miscellaneous Medical Payments	9,839,150	10,333,551	(494,401)	(5.0)%
<u>Other Payments:</u>				
Nursing Facilities	159,842,834	161,284,616	(1,441,783)	(0.9)%
ICF-MR Private	18,002,315	18,489,185	(486,870)	(2.7)%
Medicare Buy-In	44,054,026	44,652,779	(598,752)	(1.4)%
Transportation	9,013,796	9,005,820	7,975	0.1%
Part D Phase-In Contribution	20,685,771	20,840,803	(155,032)	(0.7)%
Total OHCA Medical Programs	1,050,237,693	1,022,371,499	27,866,194	2.7%
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	\$ 1,104,604,280	\$ 1,073,131,372	\$ 31,472,908	2.8%

REVENUES OVER/(UNDER) EXPENDITURES	\$ 199,946,344	\$ 214,623,169	\$ 14,676,824	
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OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2011, for the Four Months Ended October 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	\$ 8,911,454	\$ 8,761,817	\$ -	\$ 141,496	\$ -	\$ 8,141	\$ -
Inpatient Acute Care	228,186,003	195,944,293	162,229	4,378,461	16,315,054	1,404,116	9,981,850
Outpatient Acute Care	76,277,341	71,271,833	13,868	3,084,937	-	1,906,703	-
Behavioral Health - Inpatient	38,111,731	37,160,460	-	1,792	-	4,958	944,521
Behavioral Health - Outpatient	2,969,111	2,934,842	-	-	-	-	34,269
Behavioral Health Facility- Rehab	70,228,413	49,621,888	-	115,532	-	45,556	20,445,438
Behavioral Health - Case Management	218	149	-	-	-	69	-
Residential Behavioral Management	7,802,720	-	-	-	-	-	7,802,720
Targeted Case Management	25,067,326	-	-	-	-	-	25,067,326
Therapeutic Foster Care	781,161	781,161	-	-	-	-	-
Physicians	145,917,423	107,024,294	19,367	4,362,207	19,503,775	3,625,097	11,382,683
Dentists	49,657,071	47,078,537	-	3,687	2,526,076	48,771	-
Other Practitioners	19,862,510	19,216,169	148,788	167,588	307,074	22,892	-
Home Health Care	7,317,239	7,299,182	-	-	-	18,057	-
Lab & Radiology	16,896,461	15,359,247	-	1,030,073	-	507,141	-
Medical Supplies	15,200,232	14,057,491	905,945	197,042	-	39,754	-
Ambulatory Clinics	30,624,122	26,435,711	-	588,307	-	256,687	3,343,418
Personal Care Services	4,329,087	-	-	-	-	-	4,329,087
Nursing Facilities	161,284,616	103,058,427	44,935,749	-	13,290,439	-	-
Transportation	9,005,820	8,175,245	807,428	-	19,728	3,419	-
GME/IME/DME	48,061,016	-	-	-	-	-	48,061,016
ICF/MR Private	18,489,185	15,167,573	3,041,727	-	279,885	-	-
ICF/MR Public	33,666,869	-	-	-	-	-	33,666,869
CMS Payments	65,493,582	64,592,395	901,187	-	-	-	-
Prescription Drugs	112,026,700	91,825,876	-	4,999,144	14,310,677	891,003	-
Miscellaneous Medical Payments	10,333,561	9,820,011	-	10	462,026	51,515	-
Home and Community Based Waiver	51,066,054	-	-	-	-	-	51,066,054
Homeward Bound Waiver	29,156,847	-	-	-	-	-	29,156,847
Money Follows the Person	1,540,161	-	-	-	-	-	1,540,161
In-Home Support Waiver	8,056,710	-	-	-	-	-	8,056,710
ADvantage Waiver	62,410,044	-	-	-	-	-	62,410,044
Family Planning/Family Planning Waiver	2,454,453	-	-	-	-	-	2,454,453
Premium Assistance*	17,369,067	-	-	17,369,067	-	-	-
Total Medicaid Expenditures	\$ 1,378,554,310	\$ 895,586,600	\$ 50,936,288	\$ 36,439,344	\$ 67,014,733	\$ 8,833,879	\$ 319,743,467

* Includes \$17,293,576.88 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2011, for the Four Months Ended October 31, 2010

	FY11
REVENUE	Actual YTD
Revenues from Other State Agencies	\$ 118,693,067
Federal Funds	207,347,585
TOTAL REVENUES	\$ 326,040,652
EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	\$ 51,066,054
Money Follows the Person	1,540,161
Homeward Bound Waiver	29,156,847
In-Home Support Waivers	8,056,710
ADvantage Waiver	62,410,044
ICF/MR Public	33,666,869
Personal Care	4,329,087
Residential Behavioral Management	6,043,164
Targeted Case Management	20,950,102
Total Department of Human Services	217,219,039
State Employees Physician Payment	
Physician Payments	11,382,683
Total State Employees Physician Payment	11,382,683
Education Payments	
Graduate Medical Education	14,300,000
Graduate Medical Education - PMTC	887,567
Indirect Medical Education	28,813,252
Direct Medical Education	4,060,197
Total Education Payments	48,061,016
Office of Juvenile Affairs	
Targeted Case Management	834,440
Residential Behavioral Management - Foster Care	8,952
Residential Behavioral Management	1,750,604
Multi-Systemic Therapy	34,269
Total Office of Juvenile Affairs	2,628,265
Department of Mental Health	
Targeted Case Management	98
Hospital	944,521
Mental Health Clinics	20,445,438
Total Department of Mental Health	21,390,057
State Department of Health	
Children's First	689,991
Sooner Start	799,156
Early Intervention	1,667,475
EPSDT Clinic	616,996
Family Planning	18,806
Family Planning Waiver	2,428,349
Maternity Clinic	25,762
Total Department of Health	6,246,535
County Health Departments	
EPSDT Clinic	266,187
Family Planning Waiver	7,298
Total County Health Departments	273,484
State Department of Education	54,980
Public Schools	870,240
Medicare DRG Limit	8,606,106
Native American Tribal Agreements	1,635,318
Department of Corrections	35,387
JD McCarty	1,340,357
Total OSA Medicaid Programs	\$ 319,743,467
OSA Non-Medicaid Programs	\$ 21,013,542
Account Receivable from OSA	\$ 14,716,357

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2011, for the Four Months Ended October 31, 2010

REVENUES	Total Revenue	State Share
Quality of Care Assessment	\$ 17,808,567	\$ 17,808,567
Interest Earned	18,382	18,382
TOTAL REVENUES	\$ 17,826,949	\$ 17,826,949

EXPENDITURES	FY 11 Total \$ YTD	FY 11 State \$ YTD	Total State \$ Cost
Program Costs			
NF Rate Adjustment	\$ 43,683,923	\$ 15,538,371	
Eyeglasses and Dentures	95,347	33,915	
Personal Allowance Increase	1,156,480	411,360	
Coverage for DME and supplies	905,945	322,245	
Coverage of QMB's	344,252	122,450	
Part D Phase-In	901,187	901,187	
ICF/MR Rate Adjustment	1,636,154	581,980	
Acute/MR Adjustments	1,405,573	499,962	
NET - Soonerride	807,428	287,202	
Total Program Costs	\$ 50,936,288	\$ 18,698,672	\$ 18,698,672
Administration			
OHCA Administration Costs	\$ 173,290	\$ 86,645	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	\$ 173,290	\$ 86,645	\$ 86,645
Total Quality of Care Fee Costs	\$ 51,109,578	\$ 18,785,317	
TOTAL STATE SHARE OF COSTS			\$ 18,785,317

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are transferred 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 2011, for the Four Months Ended October 31, 2010

REVENUES	FY 10 Carryover	FY 11 Revenue	Total Revenue
Prior Year Balance	\$ 45,276,770	\$ -	\$ 7,303,085
State Appropriations	(30,000,000)		
Tobacco Tax Collections	-	15,915,913	15,915,913
Interest Income	-	509,332	509,332
Federal Draws	379,631	7,698,589	7,698,589
All Kids Act	(8,000,000)	-	-
TOTAL REVENUES	\$ 7,656,401	\$ 24,123,834	\$ 31,426,919

EXPENDITURES	FY 10 Expenditures	FY 11 Expenditures	Total \$ YTD
Program Costs:			
Employer Sponsored Insurance		\$ 17,293,577	\$ 17,293,577
ESI-College Students		75,491	75,491
Individual Plan			
SoonerCare Choice		\$ 138,421	\$ 49,236
Inpatient Hospital		4,350,890	1,547,612
Outpatient Hospital		3,052,480	1,085,767
BH - Inpatient Services		1,792	638
BH Facility - Rehabilitation Services		115,295	41,011
Physicians		4,330,215	1,540,258
Dentists		3,687	1,312
Other Practitioners		164,652	58,567
Home Health		-	-
Lab and Radiology		1,019,698	362,706
Medical Supplies		196,677	69,958
Ambulatory Clinics		584,127	207,774
Prescription Drugs		4,961,719	1,764,883
Miscellaneous Medical		10	3
Premiums Collected		-	(734,519)
Total Individual Plan		\$ 18,919,663	\$ 5,995,205
College Students-Service Costs		\$ 150,613	\$ 53,573
Total Program Costs		\$ 36,439,344	\$ 23,417,846
Administrative Costs			
Salaries	\$ 22,395	\$ 469,330	\$ 491,725
Operating Costs	47,512	31,749	79,261
Health Dept-Postponing	19,330	-	19,330
Contract - HP	264,080	761,624	1,025,704
Total Administrative Costs	\$ 353,316	\$ 1,262,704	\$ 1,616,019
Total Expenditures			\$ 25,033,865
NET CASH BALANCE	\$ 7,303,085		\$ 6,393,054

**OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:**

**Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2011, for the Four Months Ended October 31, 2010**

REVENUES	FY 11 Revenue	State Share
Tobacco Tax Collections	\$ 317,635	\$ 317,635
TOTAL REVENUES	\$ 317,635	\$ 317,635

EXPENDITURES	FY 11 Total \$ YTD	FY 11 State \$ YTD	Total State \$ Cost
Program Costs			
SoonerCare Choice	\$ 8,141	\$ 2,027	
Inpatient Hospital	1,404,116	349,625	
Outpatient Hospital	1,906,703	474,769	
Inpatient Free Standing	4,958	1,235	
MH Facility Rehab	45,556	11,343	
Case Mangement	69	17	
Nursing Facility	-	-	
Physicians	3,625,097	902,649	
Dentists	48,771	12,144	
Other Practitioners	22,892	5,700	
Home Health	18,057	4,496	
Lab & Radiology	507,141	126,278	
Medical Supplies	39,754	9,899	
Ambulatory Clinics	256,687	63,915	
Prescription Drugs	891,003	221,860	
Transportation	3,419	851	
Miscellaneous Medical	51,515	12,827	
Total Program Costs	\$ 8,833,879	\$ 2,199,636	\$ 2,199,636
TOTAL STATE SHARE OF COSTS			\$ 2,199,636

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are transferred 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 2011, for the Four Months Ended October 31, 2011

REVENUES	FY 11 Total Revenue	FY 11 State Share
Tobacco Tax Collections	\$ 19,033,774	\$ 19,033,774
TOTAL REVENUES	\$ 19,033,774	\$ 19,033,774

EXPENDITURES	FY 11 Total \$ YTD	FY 11 State \$ YTD	Total State \$ Cost
Program Costs:			
Adult Dental Services	\$ 2,526,076	\$ 898,525	
Remove Hospital Day Limit	3,951,100	1,405,406	
Hospital Rate Increase - Statewide Median +2%	5,678,432	2,019,818	
Increase Physician Visits from 2 to 4 per Month	163,014	57,984	
Increase Physician Office Visits/OB Visits to 90% of Medicare	9,370,364	3,333,039	
Increase Emergency Room Physician Rates to 90% of Medicare	4,436,384	1,578,022	
Pay 50% of Medicare Crossover - Physician/Ambulance/OP	6,303,113	2,242,017	
Nursing Facility 7% Rate Increase	10,629,215	3,780,812	
Enhanced Drug Benefit for Adults 3 + 3	7,718,113	2,745,333	
Enhanced Drug Benefit for Waiver Adults 3 + 10	6,592,564	2,344,975	
TEFRA Services	3,712,001	1,320,359	
SoonerRide	19,728	7,017	
Replace NSGO Medicare DRG Limit Revenues	5,914,629	2,103,834	
Total Program Costs	\$ 67,014,733	\$ 23,837,140	\$ 23,837,140
TOTAL SHATE SHARE OF COSTS			\$ 23,837,140

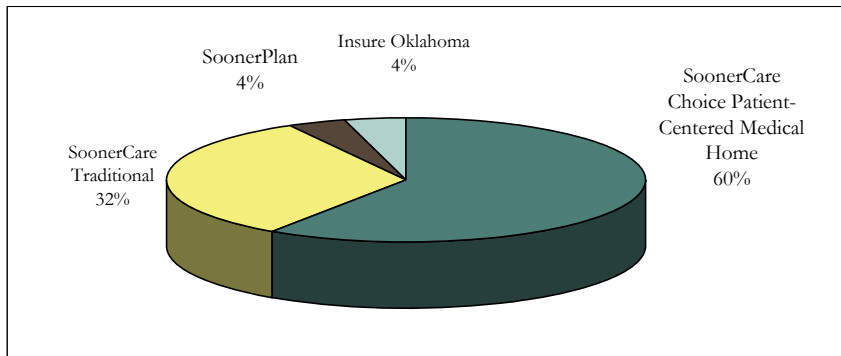
Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are transferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

SoonerCare Programs

October 2010 Data for December 2010 Board Meeting

Delivery System	Monthly Enrollment Average SFY2009	Enrollment October 2010	Total Expenditures October 2010	Average Dollars Per Member Per Month October 2010
SoonerCare Choice Patient-Centered Medical Home	435,958	451,961	\$104,365,307	
<i>Lower Cost</i> (Children/Parents; Other)		407,278	\$69,253,812	\$170
<i>Higher Cost</i> (Aged, Blind or Disabled; TEFRA; BCC)		44,656	\$35,111,495	\$786
SoonerCare Traditional	219,646	245,069	\$190,586,293	
<i>Supplemental</i> (Medicare, Third-Party Liability - Deductibles, Premiums, etc.)		117,025	\$7,643,368	\$65
<i>Lower Cost</i> (Children/Parents; Other)		109,264	\$48,946,442	\$448
<i>Higher Cost</i> (Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)		18,807	\$133,996,482	\$7,125
SoonerPlan	23,255	29,930	\$505,119	\$17
Insure Oklahoma	28,594	31,876	\$8,792,306	
<i>Employer-Sponsored Insurance</i>	17,857	19,098	\$4,283,411	\$224
<i>Individual Plan</i>	10,736	12,778	\$4,508,895	\$353
TOTAL	707,453	758,836	\$304,249,024	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data. The "Other" category includes DDSD State, PKU, Q1, Q2, Refugee, SLMB, Soon-to-be-Sooners (STBS) and TB members. Custody expenditures are excluded. Non-member specific expenditures of \$4,660,603 are excluded.



Net Enrollee Count Change from Previous Month Total	15,076
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New Enrollees	21,365
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SoonerCare Programs

Opportunities for Living Life (OLL)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	<i>Child</i>	17,395
Aged/Blind/Disabled	<i>Adult</i>	130,333
Other	<i>Child</i>	11
Other	<i>Adult</i>	18,798
PACE	<i>Adult</i>	67
TEFRA	<i>Child</i>	372
Living Choice	<i>Adult</i>	102
OLL Enrollment		167,078

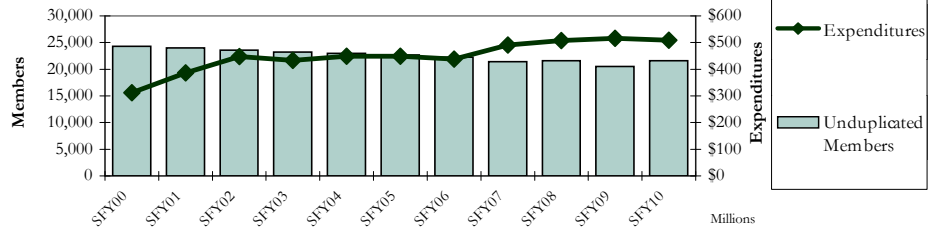
Medicare and SoonerCare	Monthly Average SFY2009	Enrolled October 2010
Dual Enrollees	100,143	103,556

	Monthly Average SFY2009	Enrolled October 2010
Long-Term Care Members	15,820	15,866
<i>Child</i>	37	91
<i>Adult</i>	15,783	15,775

PER MEMBER PER MONTH
\$4,261

SFY2010 Long-Term Care
Statewide LTC Occupancy Rate - 69.8%
SoonerCare funded LTC Bed Days 68.6%
Data as of September 2010

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



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

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts	Monthly Average SFY2009	Enrolled October 2010
Total Providers	28,000	29,557
<i>In-State</i>	19,563	20,934
<i>Out-of-State</i>	8,437	8,623

Program	% of Capacity Used
SoonerCare Choice	41%
SoonerCare Choice I/T/U	13%
Insure Oklahoma IP	3%

Select Provider Type Counts	<i>In-State Monthly Average SFY2009</i>	<i>In-State Enrolled October 2010</i>	Total Monthly Average SFY2009	Total Enrolled October 2010
Physician	5,884	6,388	10,664	11,422
Pharmacy	874	899	1,168	1,223
Mental Health Provider	915	907	983	942
Dentist	793	736	893	817
Hospital	159	186	790	662
Licensed Behavioral Health Practitioner	N/A	436	N/A	451
Extended Care Facility	394	395	395	395

Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers	4,072	4,452	6,063	6,483
Patient-Centered Medical Home	1,339	1,459	1,360	1,485

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

6.b-1 **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-42.16. [AMENDED]
Part 58. Non-Hospital Based Hospice
317:30-5-532. [AMENDED]
(Reference APA WF # 10-54)

FINDING OF EMERGENCY: The Agency has determined a necessity for promulgation of emergency rules to avoid violation of federal law or regulation or other state law and requests emergency approval of rule revisions to the Agency's hospice rules. Public Laws 111-148 and 111-152 were enacted which require hospice services be available to children eligible for Medicaid without forgoing any other services to which the child is entitled under SoonerCare for treatment of the terminal condition. Emergency rule revisions are necessary to comply with these federal regulations and Centers for Medicare & Medicaid Services (CMS) guidance.

ANALYSIS: Hospice rules are revised to allow hospice services to be available to children eligible for SoonerCare without forgoing any other service for treatment of the terminal condition. Public Laws 111-148 and 111-152 were enacted which remove the restriction that children in need of hospice that are eligible for SoonerCare have to elect hospice services in lieu of standard SoonerCare services that have the objective to treat or cure the terminal illness. Additional revisions include allowing nurse practitioners to recertify the continuation of hospice services. The revisions ensure the Agency is in compliance with federal law.

BUDGET IMPACT: Agency staff has determined that the impact of the rule revisions to the Agency is budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 17, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: 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; Public Laws 111-148 and 111-152.

RESOLUTION:

Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:

Revising the Agency's Hospice rules to require hospice services be available to children eligible for SoonerCare without forgoing any other services to which the child is entitled under SoonerCare for treatment of the terminal condition.

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS**

317:30-5-42.16. Related services

(a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the Authority's Medical Programs.

(b) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the OHCA.

(1) Payment is made for home health services provided in a member's residence to all categorically needy individuals.

(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.

(3) Payment is made for standard medical supplies.

(4) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.

(5) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).

(6) Payment may be made to home health agencies for prosthetic devices.

(A) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate.

(B) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.

(C) Sterile tracheotomy trays are covered.

(D) Payment is made for colostomy and urostomy bags and accessories.

(E) Payment is made for hyperalimentation, including supplements, supplies and equipment rental ~~in~~ on behalf of persons having permanently inoperative internal body organ dysfunction. Information regarding the member's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached when requesting prior authorization.

(F) Payment is made for ventilator equipment and supplies when prior authorized.

(G) Payment for medical supplies, oxygen, and equipment is made when using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(c) **Hospice Services.** Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits ~~in lieu of standard SoonerCare services that have the objective to treat or cure the member's illness.~~ Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility

for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.

(2) Hospice care is available for two initial 90-day periods and an unlimited number of subsequent 60-day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. ~~However, the~~ The member and/or the family may voluntarily terminate hospice services.

(3) Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the member is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify ~~or re-certify~~ the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.

(4) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

PART 58. NON-HOSPITAL BASED HOSPICE

317:30-5-532. Coverage for children

Hospice is palliative and/or comfort care provided to the ~~elient~~ member and his/her family when a physician certifies that the ~~elient~~ member has a terminal illness and has a life expectancy of six months or less ~~to live and orders hospice care.~~ A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and ~~during dying and bereavement~~ death. ~~The hospice~~ Hospice services must be related to the palliation and management of the ~~elient's~~ member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(1) Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the ~~patient~~ member and/or family has elected hospice benefits ~~in lieu of standard Medicaid services that has the objective to treat or cure the elient's illness.~~ Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the ~~elient~~ member has elected hospice care, the hospice medical team assumes responsibility for the ~~elient's~~ member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical

social services, dietary counseling and grief and bereavement counseling to the ~~elient~~ member and/or family. Services must be prior authorized.

(2) Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the ~~patient's~~ member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. However, the ~~patient~~ The member and/or the family may voluntarily terminate hospice services. To be covered, hospice Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the ~~patient's~~ member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify ~~or re-certify~~ the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness. A plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

(3) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

6.b-2 **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
317:30-5-763. [AMENDED]

CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

Subchapter 1. Medically Fragile Waiver Services
317:50-1-14. [AMENDED]
Subchapter 3. My Life, My Choice Waiver Services
317:50-3-14. [AMENDED]
Subchapter 5. Sooner Seniors Waiver Services
317:50-5-14. [AMENDED]
(Reference APA WF # 10-55A & 10-55B)

FINDING OF EMERGENCY: The Agency has determined a necessity for promulgation of emergency rules to avoid violation of federal law or regulation or other state law and requests emergency approval of rule revisions to the Agency's Home and Community Based Waiver Programs (ADvantage, Medically Fragile, My Life, My Choice & Sooner Seniors). Public Laws 111-148 and 111-152 require SoonerCare members receiving hospice to be re-evaluated after the initial six month service period to ensure that hospice continues to be medically necessary. Additional hospice services will be approved for a maximum of 60 days without another re-evaluation.

ANALYSIS: Rules are revised to include a re-evaluation and approval of additional hospice services within the Agency's Home and Community Based Waiver Programs. Agency HCBS Waiver programs allow individuals qualifying for SoonerCare long term care institutional services to live in a home or community based setting. Hospice is a service provided to SoonerCare members within the waivers, and currently has no authorization limits. Rules are revised to include a re-authorization process after the initial 6 months of hospice care. A re-evaluation of the member will be performed and additional hospice care authorized for a period not to exceed 60 days. A re-evaluation will be performed every 60 days until the member no longer requires hospice.

BUDGET IMPACT: Agency staff has determined that the revisions will result in \$868,000 total annual savings; \$217,000 state share savings; OKDHS is responsible for any state share costs/savings associated with the ADvantage Waiver Program.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 17, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: 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; Public Laws 111-148 and 111-152.

RESOLUTION:

Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:

Revising Agency rules to include a re-evaluation and approval of additional hospice services provided under the Agency's Home and Community Based Waiver Programs.

**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES**

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) Case Management.

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

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

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

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

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

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

(ii) Very Rural/Difficult Service Area Rate: Case Management

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

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

(2) **Respite.**

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

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

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

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

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the member. Physical, occupational, respiratory and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Transportation between the member's residence and the service setting is provided as a part of Adult Day Health Care. Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing and/or hair washing will be authorized when an ADvantage waiver member who uses adult day health care requires assistance with bathing and/or hair

washing to maintain health and safety.

(B) Adult Day Health Care is a 15-minute unit. No more than 6 hours are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

(4) Environmental Modifications.

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

(B) All services require prior authorization.

(5) Specialized Medical Equipment and Supplies.

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

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

(6) Advanced Supportive/Restorative Assistance.

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

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(7) Nursing.

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed

to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

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

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

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

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

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

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

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

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

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

(V) providing consultation and education to the member,

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

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) Home Delivered Meals.

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

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

(9) Occupational Therapy services.

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

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

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

(10) Physical Therapy services.

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

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

(11) Speech and Language Therapy Services.

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

documentation.

(12) **Respiratory Therapy Services.**

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

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

(13) **Hospice Services.**

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

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

to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ADvantage Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for ADvantage Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

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

(14) ADvantage Personal Care.

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

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

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

(15) Personal Emergency Response System.

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

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

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

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

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

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

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

(B) PERS services are billed using the appropriate HCPC procedure code

for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the ADvantage approved plan of care.

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

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

- (i) recruits, hires and, as necessary, discharges the PSA or APSA;
- (ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASPA's personnel file;
- (iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;
- (iv) supervises and documents employee work time; and,
- (v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:

- (i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;
- (ii) assistance with routine bodily functions that may include:
 - (I) bathing and personal hygiene;
 - (II) dressing and grooming;
 - (III) eating including meal preparation and cleanup;
- (iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;
- (iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

(C) Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the

opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

- (i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
- (ii) remove external catheters, inspect skin and reapplication of same;
- (iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with members without contraindicating rectal or intestinal conditions;
- (iv) apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
- (v) use lift for transfers;
- (vi) manually assist with oral medications;
- (vii) provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;
- (viii) apply non-sterile dressings to superficial skin breaks or abrasions; and
- (ix) use Universal precautions as defined by the Center for Disease Control.

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

- (i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;
- (ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;
- (iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;
- (iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and
- (v) for making available Hepatitis B vaccine and vaccination series

to PSA and APSA employees in compliance with OSHA standards.

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

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

(17) Institution Transition Services.

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

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received ADvantage services but have been referred by the OKDHS/ASD to the Case Management Provider for assistance in transitioning from the institution to the community with ADvantage services support.

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

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

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

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

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

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

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

(D) If the member has received Institution Transition Services but

fails to enter the waiver, any Institution Transition Services authorized and provided are reimbursed as "Medicaid administrative" costs and providers follow special procedures specified by the OKDHS/ASD to bill for services provided.

(18) Assisted Living Services.

(A) Assisted Living Services are personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance (to the extent permitted under State law). The assisted living services provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center. Nursing services are incidental rather than integral to the provision of assisted living services. ADvantage reimbursement for Assisted Living Services includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the participant as determined through individualized assessment and documented on the participant's service plan.

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

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

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

(I) unit availability;

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

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

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

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate individuals who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of

placement is not a unilateral determination by the ALC. The ADvantage Case Manager, the member and/or member's designated representative and the ALC in consultation determine the appropriateness of placement.

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

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

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

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

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

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

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

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

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

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

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

(II) The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well being of other residents and the ALC has documented efforts to resolve

behavior problems including medical interventions, behavioral interventions and increased staffing interventions. Documentation must support that ALC attempted interventions to resolve behavior problems;

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

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

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the assisted living center must inform the member and/or the member's representative, if any, and the member's ADvantage Case Manager. The ALC must develop a discharge plan in consultation with the member, the member's support network and the ADvantage Case Manager. The ALC and Case Manager must ensure that the discharge plan includes strategies for providing increased services, when appropriate to minimize risk and meet the higher care needs of members awaiting a move out of the ALC, if reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage Case Manager, giving the member 30 days notice of the ALC's intent to terminate the residency agreement and move the member to a more appropriate care provider. The 30 day requirement shall not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when termination of the residency agreement is necessary for the physical safety of the member or other residents of the ALC. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

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

(II) the date of the notice;

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

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

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

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

(i) Physical environment

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

(II) The ALC must provide each unit with a means for each member resident to control the temperature in the individual living unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the

resident and that preserves resident privacy, independence and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

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

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

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

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

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

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

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

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

(ii) Sanitation

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

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

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

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

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

(iii) Health and Safety

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

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

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

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

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

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

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

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

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

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

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

(iv) Staff to resident ratios

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

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

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

(v) Staff training and qualifications

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

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

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

towards the four hours of annual training.

(vi) Staff supervision

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

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

(vii) Resident rights

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

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

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

(viii) Incident reporting

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

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

(III) Reports of incidents must be made to the member's ADvantage Case Manager via facsimile or by telephone within one business day of the reportable incident's discovery. A follow-up report of the incident must be submitted via facsimile or mail to the member's ADvantage Case Manager within five business days after the incident. The final report must be filed with the member's ADvantage Case Manager and to the ADvantage Administration when the full investigation is complete not to exceed ten business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either the Oklahoma Department of Human Services, the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred or the local municipal police department or sheriff's

department as soon as the person is aware of the situation, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes. Reports should also be made to the OSDH, as appropriate, in accordance with the ALC's licensure rules.

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

(ix) Provision of or arrangement for necessary health services

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

(II) The ALC must provide or coordinate with the member and the member's ADvantage Case Manager for delivery of necessary health services. The ADvantage Case Manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the service plan are provided in an appropriate and timely manner.

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

CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-14. Description of services

Services included in the Medically Fragile Waiver Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or skilled nursing facility services, the case manager assists the member

in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Medically Fragile Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

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

(i) A billable case management activity is any task or function defined under OAC 317:50-1-15(1)(A) that only a Medically Fragile case manager because of skill, training or authority, can perform on behalf of a member;

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

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

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

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

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

(2) **Respite.**

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

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided

with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

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

(3) **Environmental Modifications.**

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

(B) All services require prior authorization.

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

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

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

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

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

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(6) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual

and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

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

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

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

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

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

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

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

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

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

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

and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(7) Home Delivered Meals.

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

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

(8) Occupational Therapy services.

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

services, based on the member's condition and ongoing rehabilitation potential.

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

(9) Physical Therapy services.

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

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

(10) Speech and Language Therapy services.

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(11) Respiratory Therapy Services.

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require

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

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

(12) **Hospice Services.**

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

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

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

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

(13) **Medically Fragile Waiver Personal Care.**

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

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

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

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

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

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

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

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

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

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

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

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

(15) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(16) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

- (i) residence in the Self-Directed services approved area;
- (ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

- (i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction

responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, and Advanced Supportive/Restorative Care. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

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

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

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

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

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

(G) Financial Management Services are program administrative services

provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

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

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

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

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

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

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

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet

additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

SUBCHAPTER 3. MY LIFE, MY CHOICE WAIVER SERVICES

317:50-3-14. Description of services

Services included in the My Life, My Choice Waiver Program are as follows:

(1) **Case Management.**

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

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

(i) A billable case management activity is any task or function defined under OAC 317:50-3-14(1)(A) that only a My Life, My Choice case manager because of skill, training or authority, can perform on behalf of a member;

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

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

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

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

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

(2) **Respite.**

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

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

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

(3) **Environmental Modifications.**

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

(B) All services require prior authorization.

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

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

(B) Specialized Medical Equipment and Supplies are billed using the

appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

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

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

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(6) **Nursing.**

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

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

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

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

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

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

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

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

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

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

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

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

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(7) Home Delivered Meals.

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

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The

provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(8) Occupational Therapy services.

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(9) Physical Therapy services.

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

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

(10) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(11) **Respiratory Therapy services.**

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

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

(12) **Hospice services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders ~~Hospice Care~~ hospice care. My Life, My Choice Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-

certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for My Life, My Choice Facility Based Extended Respite. Hospice provided as part of Facility Based Extended respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive My Life, My Choice Hospice services.

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

(13) **My Life, My Choice Waiver Personal Care.**

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

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

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

(14) **Adult Day Health.** Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the

member. Transportation between the member's place of residence and the adult day facility is provided and is included in the rate paid to providers of adult day health services.

(15) **Assistive Technology.** Assistive technology enables the member to maintain or increase functional capabilities. Assistive technology devices are in addition to equipment and supplies readily available through traditional State Plan services and exclude items that are not of direct medical or remedial benefit to the member. Assistive technology includes the purchase, rental, customization, maintenance and repair of such devices.

(16) **Audiology Treatment and Evaluation.** Services include evaluation, treatment and consultation related to auditory functioning and are intended to maximize the member's hearing abilities.

(17) **Agency Companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include 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;

(18) **Dental services.** Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed \$1,000 per plan year of care. These services may include:

(A) oral examination;

(B) bite-wing x-rays;

(C) prophylaxis;

(D) topical fluoride treatment;

(E) development of a sequenced treatment plan that prioritizes:

(i) elimination of pain;

(ii) adequate oral hygiene; and

(iii) restoration or improved ability to chew;

(F) routine training of member or primary caregiver regarding oral hygiene; and

(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(19) **Family Training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(20) **Family Counseling.** Family counseling helps to develop and maintain healthy, stable relationships among all family members in order to support meeting the needs of the member. Emphasis is placed on the acquisition of coping skills by building upon family strengths. Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home. Services are intended to maximize the member/family's emotional/social adjustment and well-being. All family counseling needs are documented in the member's plan of care. Individual counseling cannot exceed 400, 15-minute units per plan of care year. Group counseling cannot exceed 225, 30-minute units per plan of care year. Case Managers assist the member to identify

other alternatives to meet identified needs above the limit.

(21) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

(22) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(23) **Independent Living Skills training.** Independent living skills training is a service to support the individual's self care, daily living, adaptive skills and leisure skills needed to reside successfully in the community. Services are provided in community based settings in a manner that contributes to the individual's independence, self sufficiency, community inclusion and well being. This service is intended to train members with significant cognitive problems living skills such as selecting clothing, dressing, and personal shopping.

(24) **Personal Emergency Response System.**

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

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

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

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

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

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

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

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

(25) **Prescription drugs.** Members are eligible for a maximum of six

prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(26) **Psychiatry.** Psychiatry provides outpatient psychiatric services provided by a licensed psychiatrist and will be comprised of diagnosis, treatment and prevention of mental illness. These services will also include review, assessment and monitoring of psychiatric conditions, evaluation of the current plan of treatment and recommendations for a continued and/or revised plan of treatment and/or therapy, including required documentation. Psychiatrists may provide instruction and training to individuals, family members, case management staff and/or provider staff in recognition of psychiatric illness and adverse reactions to medications.

(27) **Psychological services.** Psychological services include evaluation, psychotherapy, consultation and behavioral treatment. Services are provided in any community setting as specified in the member's service plan. Services are intended to maximize the member's psychological and behavioral well-being. Services are provided in both individual and group (8 person maximum) formats. The OHCA Care Management Team will review service plans to ensure that duplication of services does not occur.

(28) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:

(A) An initial medication assessment performed in conjunction with the case manager and member.

(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.

(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.

(29) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRide NET services is located at 317:30-5-326.

(30) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's

service eligibility to participate in the Self-Directed Services program:

- (i) residence in the Self-Directed services approved area;
- (ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

- (I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

- (II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

- (III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

- (i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

- (ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

- (iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

- (iv) the member abuses or exploits their employee; or

- (v) the member falsifies time-sheets or other work records; or

- (vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their

Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

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

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

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

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

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

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

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

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

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

(iv) providing to the member, as needed, assistance with employer

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

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

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

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

SUBCHAPTER 5. SOONER SENIORS WAIVER SERVICES

317:50-5-14. Description of services

Services included in the Sooner Seniors Waiver Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services,

regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Sooner Seniors Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

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

(i) A billable case management activity is any task or function defined under OAC 317:50-5-14(1)(A) that only a Sooner Seniors case manager because of skill, training or authority, can perform on behalf of a member;

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

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

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

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

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

(2) **Respite.**

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

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is billed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is billed for a per diem rate. A minimum of eight hours must be provided in the member's home.

(3) **Environmental Modifications.**

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

(B) All services require prior authorization.

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

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

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

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

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

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(6) **Nursing.**

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

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

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

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

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

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

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

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

disorientation or confusion;

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

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

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

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(7) Home Delivered Meals.

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

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

(8) Occupational Therapy services.

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or

environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(9) **Physical Therapy services.**

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

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

(10) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to

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

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

(11) Respiratory therapy services.

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

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

(12) Hospice services.

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

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home

environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Sooner Seniors Facility Based Extended Respite. Hospice provided as part of Facility Based Extended respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Sooner Seniors Hospice services.

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

(13) **Sooner Seniors Waiver Personal Care.**

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

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

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

(14) **Adult Day Health.** Adult Day Health services are scheduled for one or more days per week, in a community setting, encompassing both health and social services needed in order to provide optimal functioning of the member. Transportation between the member's place of residence and the adult day facility is provided and is included in the rate paid to providers of adult day health services.

(15) **Agency companion.** Agency companion services provide a living arrangement developed to meet the specific needs of the member that include 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;

(16) **Dental services.** Dental services include maintenance or improvement of dental health as well as relief of pain and infection. Coverage of dental services may not exceed \$1,000 per plan year of care. These services may include:

- (A) oral examination;
- (B) bite-wing x-rays;
- (C) prophylaxis;
- (D) topical fluoride treatment;

(E) development of a sequenced treatment plan that prioritizes:

- (i) elimination of pain;
- (ii) adequate oral hygiene; and
- (iii) restoration or improved ability to chew;

(F) routine training of member or primary caregiver regarding oral hygiene; and

(G) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable.

(17) **Family training.** Family training services are for families of the member being served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a waiver member and may include a parent, spouse, children relatives, foster family or in-laws. Training includes instruction for the family member in skills and knowledge pertaining to the support and assistance of the waiver member. This training is specific to an individual member's needs. It is intended to allow the member's family to become more proficient in meeting the needs of the member. Specific family training services are included in the member's service plan.

(18) **Nutritional Education services.** Nutritional Education services focus on assisting the member and/or primary caregiver with the dietary aspects of the member's disease management. These services include dietary evaluation and consultation with individuals or their care provider. Services are provided in the member's home or when appropriate in a class situation. Services are intended to maximize the individual's nutritional health. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness.

(19) **Vision services.** Vision services must be listed in the member's plan of care and include a routine eye examination for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of glasses to include lenses and frames; exceptions are made on the individual basis as deemed medically necessary. Amount, frequency and duration of services is prior authorized in accordance with the member's service plan, with a limit of one pair of glasses to include lenses and frames annually.

(20) **Personal Emergency Response System.**

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

- (i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;
- (ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
- (iii) demonstrates capability to comprehend the purpose of and activate the PERS;
- (iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,
(vi) the service avoids premature or unnecessary institutionalization of the member.

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

(21) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(22) **Pharmacological Evaluations.** Pharmacological evaluations are provided to waiver members to ensure proper management of medications. The evaluations consist of:

(A) An initial medication assessment performed in conjunction with the case manager and member.

(B) A written report after completion of both the initial visit and medication assessment to be provided to the case manager and prescribing physician(s). The report will contain the initial medication assessment and recommendations when appropriate.

(C) Follow-up visit, assessments and reports will be arranged with the case manager every four months after the initial visits, assessment and report for the first year the member is in the community. This will result in a total of three follow-up visits, assessments and reports per member.

(23) **Non-emergency Transportation.** Non-emergency, non-ambulance transportation services are available through the SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible members. SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. The NET must be for the purpose of accessing medically necessary covered services for which a member has available benefits. Additionally, SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare. More information on SoonerRide NET services is located at 317:30-5-326.

(24) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services approved area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following

findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process

and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Advanced Supportive/Restorative Care and Respite. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

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

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

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

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

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

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

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

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

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

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

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

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

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

Oklahoma Electronic Health Record (EHR) Incentive Program Update



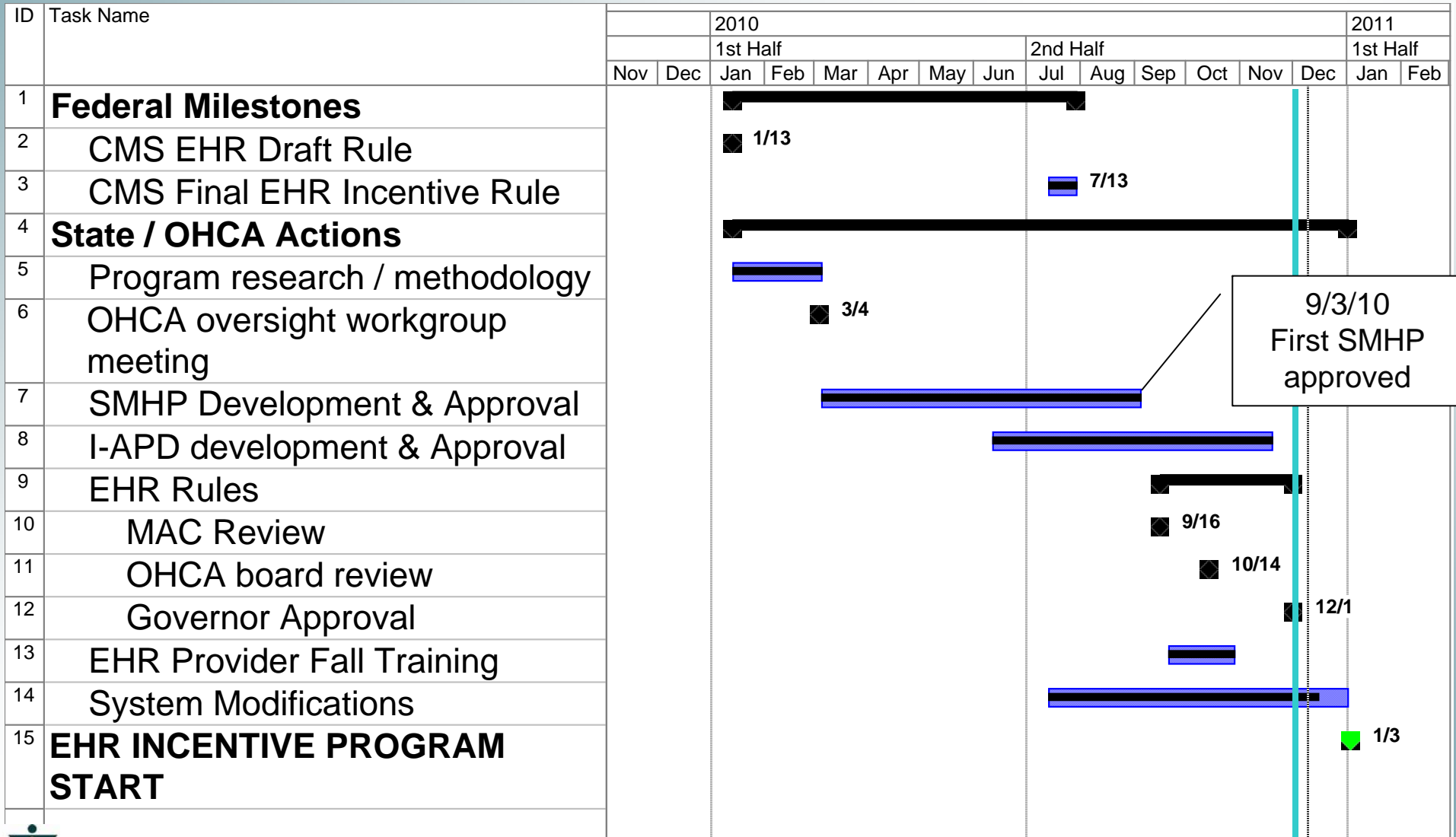
**OHCA Board Meeting
December 9, 2010**

www.okhca.org/EHR-incentive

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Oklahoma's EHR Incentive Program

Development and Implementation Timeline (Phase I)



Oklahoma's EHR Incentive Program

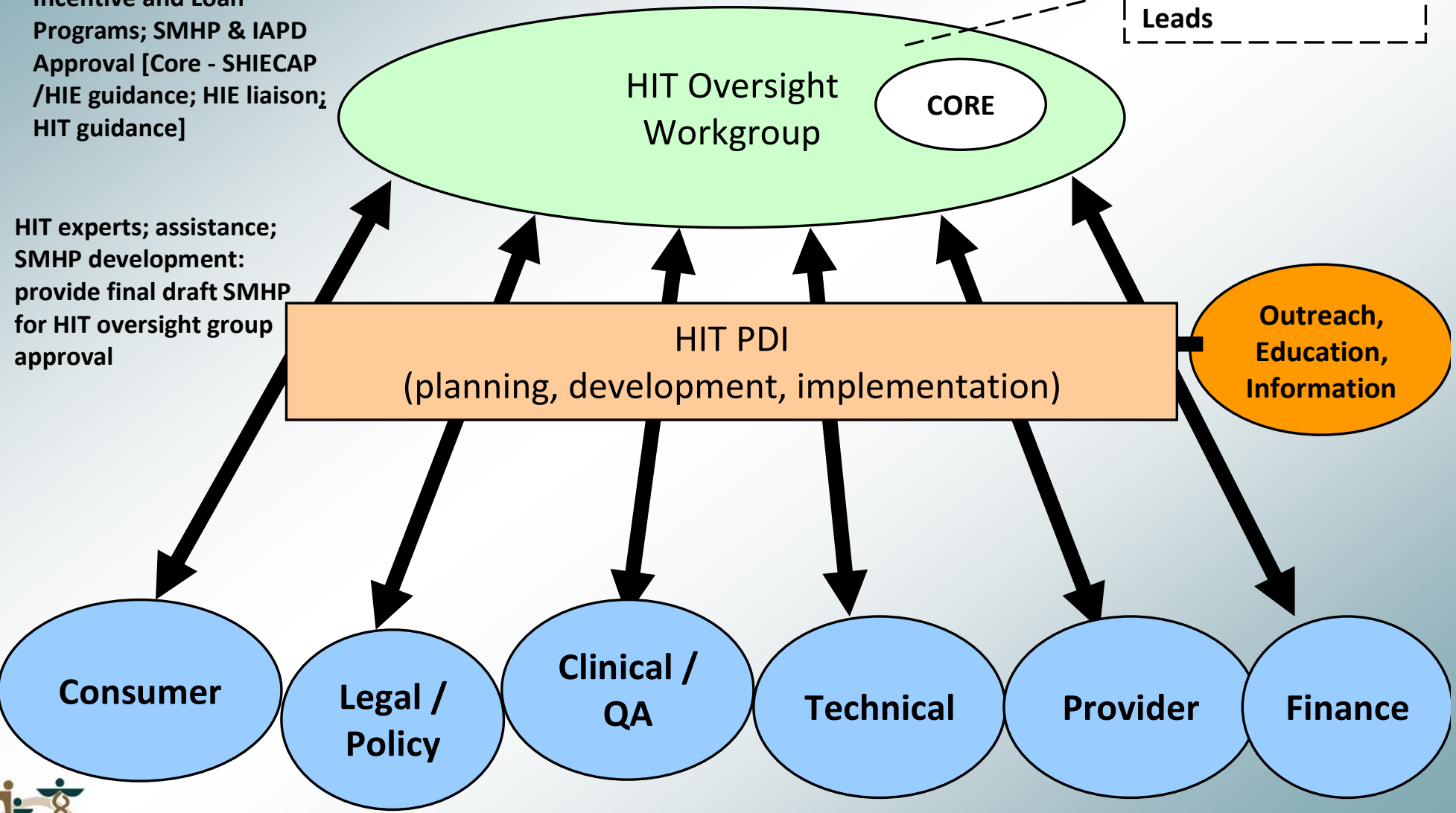
HIT Oversight Workgroup

Organizational Structure

Guidance for Medicaid Incentive and Loan Programs; SMHP & IAPD Approval [Core - SHIECAP /HIE guidance; HIE liaison; HIT guidance]

HIT experts; assistance; SMHP development: provide final draft SMHP for HIT oversight group approval

Core, Exec Staff, HIT PDI, Work Group Leads



Oklahoma's EHR Incentive Program

Next Steps

- Phase I, Stage II - EHR system enhancements
- Phase II - interface with the State Health Information Exchange (HIE)
- Phase III – Automated collection of meaningful use data

Oklahoma EHR Incentive Program

EHR Incentive Eligibility:

Qualifying Eligible Professionals (EP)

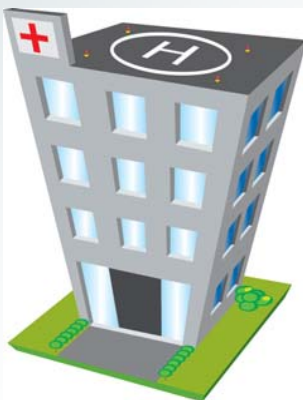
1	Current SoonerCare Provider Contract / Agreement
2	Hospital-based EPs are NOT eligible 90% or more of services are performed in a hospital inpatient or emergency room setting.
3	<div data-bbox="433 751 717 1041" data-label="Image"> </div> <p>Provider Type</p> <p>Physicians (MD,DO)</p> <p>Pediatricians</p> <p>Dentists</p> <p>Certified Nurse Midwives</p> <p>Nurse Practitioners</p> <p>Physician Assistants (PA) practicing at a FQHC/RHC so led by a PA</p>
4	<p><u>Patient Volume</u> over a 90 day period in the previous calendar year</p> <p>30% SoonerCare</p> <p>20-29% SoonerCare - Pediatricians = 2/3 of incentive payment</p> <p>30% Needy Individuals* Medical EPs practicing predominantly in FQHC or RHC</p>

* Needy individuals = SoonerCare members, patients receiving uncompensated care and patients receiving services at reduced or no cost, based upon ability to pay

Oklahoma EHR Incentive Program

EHR Incentive Eligibility:

Qualifying Eligible Hospitals (EH)

1	Current SoonerCare Provider Contract		
2	Hospital Types 	Acute Care Hospital (includes CAHs & Cancer Hospitals)	Avg. length of stay \leq 25 days CCN* last 4 of 0001 – 0879; 1300 – 1399
		Children’s Hospital	CCN* last 4 of 3300 – 3399
			Not applicable to children’s wings of larger hospitals
3	Patient Volume over a 90 day period in the previous fiscal year	Acute Care Hospital	10% SoonerCare
		Children’s Hospitals	No Requirement

Oklahoma EHR Incentive Program



Incentive to . . .

- **Adopt** (*acquire and install*)
- **Implement** (*commenced utilization, train staff, deploy tools, exchange data*)
- **Upgrade** (*expand functionality or interoperability*)

Or...

- **Meaningfully Use** (*meet specified criteria*)

. . . a certified EHR System

Oklahoma EHR Incentive Program

Registration & Attestation Process

- SoonerCare Provider registers with CMS
- CMS directs providers to the OHCA website for enrollment in the Oklahoma EHR incentive program
- Providers fill out attestation
 - CMS Registration number
 - Identify your ONC-ATCB* certified EHR system
 - Provide the number of jobs created
 - Electronically sign contract amendment and fax requested supporting documentation to OHCA



*Office of the National Coordinator for Health Information Technology – Authorized Testing and Certification Body

Oklahoma EHR Incentive Program

Eligible Professional Payments

- Paid in alignment with the Calendar Year (CY)
- First year amount consistent regardless of stage (AIU or MU)
- Maximum incentives are \$63,750 over 6 years
- Incentives are same regardless of start year
- The first year maximum payment is \$21,250
- Must begin by 2016 to receive incentive payments
- No requirement for “consecutive years” participation
- Incentives available through 2021
- Only 1 incentive payment per year

Oklahoma EHR Incentive Program

Eligible Hospital Payments

- Paid in alignment with the Federal Fiscal year (FFY)
- First year amount consistent regardless of stage (AIU or MU)
- \$2M base + per discharge amount (based on Medicare/Medicaid share)
- Achievement of Medicare Meaningful Use requirements will be deemed achievement of Medicaid Meaningful Use requirements
- Payment is calculated, then disbursed over 3 years (50 / 40 / 10)
- Hospitals cannot initiate payments after 2016 and payment years must be consecutive after 2016
- States must use auditable data sources in calculating the hospital incentive (e.g., cost report)
- Payments through 2018



Oklahoma EHR Incentive Program

Monitoring / Oversight / Audit

- Attest to specific requirements
- Provide required documentation
- Keep supporting documentation on file
- Random sample and targeted sample reviews will be conducted



Oklahoma EHR Incentive Program Common Acronyms

AAC	Average Allowable Cost	EH	Eligible Hospital	MU	Meaningful Use
ACA	Patient Protection and Affordable Care Act	EHR	Electronic Health Record	NPI	National Provider Identifier
A/I/U or AIU	Adopt, Implement, or Upgrade	EP	Eligible Professional	NPRM	Notice of Proposed Rulemaking
ARRA	American Recovery & Reinvestment Act of 2009	EPE	Electronic Provider Enrollment	OMB	Office of Management and Budget
CAH	Critical Access Hospital	FFS	Fee-for-Service	ONC	Office of the National Coordinator of Health Information Technology
CCN	CMS Certification Number	FFY	Federal Fiscal Year	ONC-ATCB	Office of the National Coordinator of Health Information Technology - Authorized Testing and Certification Body
CHIP	Children's Health Insurance Program	FY	Fiscal Year	PA	Physician Assistant
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009	FQHC	Federally Qualified Health Center	Recovery Act	American Reinvestment & Recovery Act of 2009
CMS	Centers for Medicare & Medicaid Services	HHS	U.S. Department of Health and Human Services	RHC	Rural Health Clinic
CPOE	Computerized Physician Order Entry	HIT	Health Information Technology	SMHP	State Medicaid Health Information Technology Plan
CQM	Clinical Quality Measures	HITECH Act	Health Information Technology for Economic and Clinical Health Act	SSN	Social Security Number
CY	Calendar Year	IAPD	Implementation Advanced Planning Document	TIN	Taxpayer Identification Number