OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
October 13, 2011 at 1:00 P.M.
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Ponca Conference Room
Oklahoma City, Oklahoma

A G E N D A

Items to be presented by Lyle Roggow, Chairman

1. Call to Order / Determination of Quorum
2. Welcome New Board Member – Carol Robison
3. Action Item – Approval of August 24 - 26, 2011 OHCA Board Minutes

Item to be presented by Mike Fogarty, Chief Executive Officer

4. 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) Presentation of All Star Employees

Items to be presented by Juarez McCann, Chief Budget Officer

5. Discussion Item – Fiscal Year 2013 Budget Requests

Items to be presented by Lyle Roggow, Chairman

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

    a) Audit/Finance Committee – Member Miller
    b) Rules Committee – Member McVay

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

7. Announcements 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

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

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

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

8.b-1 AMENDING Agency rules at OAC 317:30-5-763 to remove respiratory therapy as an allowable service within the ADvantage Waiver program and remove Hospice when the member is in a nursing facility receiving ADvantage Facility Based Extended Respite. Both services are removed due to lack of utilization. Additionally, rules are revised to remove language allowing for reimbursement to providers of case management transition services when the members fails to transition into the Advantage waiver program. The revisions are necessary to align OHCA policy with revised operational procedures as approved by the Centers for Medicare and Medicaid Services (CMS).

8.b-2 AMENDING Agency rules at OAC 317:2-1-2, 2-1-15 and 30-5-58 to establish guidelines for and implement the Supplemental Hospital Offset Payment Program (SHOPP) as authorized by 63 Okla. Stat. §§ 3241.1 through 3241.6. OHCA is required by the SHOPP Act to assess all in-state hospitals, unless specifically exempted, an assessment fee of 2.5%. Funds derived from the assessment will be used to garner federal matching funds which will be used to maintain SoonerCare provider reimbursement rates as well as pay participating hospitals a quarterly access payment.

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

9. Action Item – Consideration and Vote Upon the recommendations of the State Plan Amendment Rate Committee

   a) Consideration and Vote Upon Children's Long Term Care Sub-Acute Hospitals

   b) Consideration and Vote Upon Public Health Clinic Services

   c) Consideration and Vote Upon Supplemental Outpatient Hospital Payment to Level I Trauma Centers

   d) Consideration and Vote Upon Proposed Reimbursement Method for Nursing Facilities Serving Adults

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

10. Action Item – Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Okla. Stat. 5030.3.

   a) Consideration and vote to add Type 2 Diabetes Medications to the product-based prior authorization program under OAC 317:30-5-77.3.

   b) Consideration and vote to add the following products to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
      1) Zuplenz™ (ondansetron)
      2) Xiaflex® (Collagenase Clostridium Histolyticum)
      3) Cinryze® and Berinert® (C1 esterase inhibitor)
      4) Kalbitor® (ecallentide)

Item to be presented by Beth VanHorn, Director of Legal Operations

11. Action Item – Consideration and Vote to authorize expenditure of funds for the Sooner Care Call Center.

Item to be presented by Chairman Roggow

12. **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)**

Status of Pending suits and claims

1.	Association for Direct Care Trainers v. OHCA	CJ-08-4237	Oklahoma County, OK
2.	Choices v. OHCA	CJ-09-229-01	Garfield County, OK
3.	Peak v. HHS	10-CV-597-TCK PJC	USDC, Western District
4.	Morris v. OHCA	10-62441	10th Circuit Court of Appeals
5.	Gohl v. OHCA	108,993	Oklahoma Supreme Court
6.	Lexis-Nexis v. OHCA	CS-2011-4327	Oklahoma County, OK
7.	Hauenstein v. OHCA	CIV-10-940-M	USDC, Western District
8.	Morehead v. OHCA	CJ-07-1110	Cleveland County, OK
9.	Wittenberg v. OHCA	10-CV-0238	Oklahoma County, OK
10.	Daily v. OHCA	CJ-2008-85	Dewey County, OK
11.	Moore v. OHCA	CJ-2008-88	Dewey County, OK
12.	Page v. OHCA	CJ-2008-43	Dewey County, OK

Item to be presented by Chairman Roggow

13. New Business

14. ADJOURNMENT

NEXT BOARD MEETING
November 10, 2011
Oklahoma Health Care Authority – Ponca Room
Oklahoma City, Oklahoma

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
August 24, 2011
Held at the Hyatt Regency Hotel
100 East Second Street
Tulsa, OK

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on August 22, 2011.

Pursuant to a roll call of the members, a quorum was declared to be present, and Vice Chairman Armstrong called the meeting to order at 4:00 p.m.

BOARD MEMBERS PRESENT:	Vice Chairman Armstrong, Member McVay, Member Bryant, Member McFall, Member Miller (4:02 pm) and Chairman Roggow (4:50 pm)
BOARD MEMBERS ABSENT:	Member Langenkamp

OTHERS PRESENT:	OTHERS PRESENT:
Mike Forrester, Optum	Judy Goforth Parker, Chickasaw Nation
Don Henderson, Integris	Rebecca B. Smith, OKAMA/MCEMS
Dan Shivers, Optum Health	Will Widman, HP
Josh Cook, HP	Doug Cox, MD, OK House of Representatives
Becky Moore, OAHCP	Charles Brodt, HP
Sandra Harrison, DHS	C. Conley Tunnell, Daybreak Family Services
Paul Darden, OUHSC	Ed Long, OHCA
Melinda Jones, OHCA	Lisa Gardner, OHCA
Tywanda Cox, OHCA	Jerry Scherer, OHCA
Lynn Puckett, OHCA	N P Thard, OHCA
LaDawn Fulgenzi, OHCA	

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD JULY 14, 2011

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:	Member McFall moved for approval of the July 14, 2011, board minutes as published. Member McVay Seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Bryant, Member McFall
BOARD MEMBERS ABSENT:	Member Miller Member Langenkamp Chairman Roggow

FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported that Revenues for the OHCA through June, accounting for receivables, were **$3,232,784,486** or **(.8%) under** budget. Expenditures for the OHCA, accounting for encumbrances, were **$3,375,930,176** or **1.4% under** budget. The state dollar budget variance through June is **$22,525,991 positive**.

Ms. Evans said the prior year carryover was reduced by **$10,000,000** due to the Office of State Finance redistribution of State Fiscal Stabilization Funds.

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

Expenditures:		
Medicaid Program Variance		14.4
Administration		7.7
Revenues:		
Prior Year-Reduction		(10.0)
Taxes and Fees		2.3
Drug Rebate		6.1
Overpayments/Settlements		2.0
Total FY 11 Variance	**$**	**22.5**

For a detailed report, see Item 3a of the board packet.

Mr. Fogarty also introduced and welcomed Jerry Scherer, new Chief Information Officer for the OHCA, and recognized Terrie Fritz, Marianne Lingle, Linda Moffatt, Emma Sutton, Jolene Ring and Trevlyn Cross, all retiring staff members

MEDICAID DIRECTOR'S UPDATE
Garth Splinter, M.D.

Dr. Splinter went over the data sheet stating that enrollment is still about the same, being down about 9,000 in total from the previous month. There are not enough accumulated months to provide PMPM data, but we are moving toward having enough cumulative data to begin reporting. The OLL continues to be flat on the nursing homes and costs. Net providers stayed about the same with no real decreases in any of those areas. Access through the provider

network continues to look good. On the EHR incentives, 69 payments were made in June, bringing the total to 636 payments for an amount of $35,611,710. A new section of the data sheet has been added to reflect quality of health numbers. The numbers shown are our HEDIS measures. It is important to have these metrics so that we can measure ourselves and set goals. One qualifier to this information is that the numbers are HEDIS like, not exactly the same as HEDIS numbers and compare two different years.

Additional charts were presented reflecting: 1) the total average monthly enrollment per fiscal year since going to managed care; 2) SoonerCare member demographics by race and ethnicity; 3) Statewide, By County, Primary Care Providers Percent of Change; and 4) several different charts regarding Licensed Behavioral Health Professionals.

For a detailed report, see Item 3b of the board packet.

CEO, Mike Fogarty, commented that one number on these charts really jumps out at him. That number is that of contracted dentists which is 1,035. There was a time when this number was approximately 150 statewide. This has made a tremendous difference for our members.

At this time, Vice-Chairman Armstrong stated that the board would move on to agenda item 5 and come back to agenda item 4 later in the meeting.

ITEM 5 / CONSIDERATION AND VOTE FOR AUTHORIZATION TO EXPEND FUNDS FOR LEGAL REPRESENTATION OF COVINGTON & BURLING LLP

Howard Pallotta, Director of Legal Services on behalf of Beth Van Horn, Director of Legal Operations

Mr. Pallotta explained that Covington & Burling is a Washington, DC law firm that has been used by the OHCA for a long time. The firm primarily represents the OHCA on federal disallowances, which we have from time to time, and which are generally large dollar. Rules require that we come to the OHCA Board for an approval to expend funds whenever there is a change of $125,000 in a contract. The contract period is July 1 to June 30. The contract must also be approved by the Attorney General which has occurred.

Member Miller stated that he was extremely familiar with this firm, having done work with them for a number of years. He believes it to be some of the best money spent.

For more detailed information, see Item 5 of the board packet.

MOTION:	Member Miller moved for approval of Item 5 as recommended. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Bryant, Member Miller and Member McFall
BOARD MEMBERS ABSENT:	Member Langenkamp Chairman Roggow

ITEM 4 / PRESENTATION OF T.J. BRICKNER DEFENDER OF HEALTH AWARD
Anthony Armstrong, Vice-Chairman and Mike Fogarty, CEO

Mr. Fogarty began by giving a brief history of the award, which was first presented to its namesake, Dr. T.J. Brickner, in 2005. The award was created to recognize some of the best examples of dedication and personal commitment to low-income uninsured and underinsured residents in Oklahoma.

Mr. Armstrong announced that the 2011 winner of the T.J. Brickner Defender of Health Award is Dr. Doug Cox, and along with Mr. Fogarty, read a synopsis of Dr. Cox's contributions to the citizens of the State of Oklahoma. Dr. Cox expressed his appreciation for the award and was honored to be in the same company as previous recipients.

At this time, Mr. Armstrong also recognized Board Secretary, Sue Branstetter, who is retiring on September 30, 2011, after 21 plus years of service for the State of Oklahoma. Mike Fogarty was also recognized for achieving 30 years of service for the State of Oklahoma.

Dr. Doug Cox, a member of the Oklahoma House of Representatives, then addressed the OHCA Board expressing his pleasure for all that had been accomplished and the concern of legislators with fiscal impact and balancing the budget. Of specific concern is the fact that health care is consuming an increased amount of state budget. With this in mind, Dr. Cox proposed three cost saving measures for the Board's consideration.

Proposal Number 1 – Limit Emergency Room and Minor Emergency Center Visits to 4 per 12 month period.

A significant number of Medicaid recipients are overusing the Emergency Room, and are using it for non-emergent conditions and for convenience. Unfortunately, some use it for drug seeking and chronic care. Dr. Cox's conservative estimates indicate that limiting Medicaid ER visits to 4 per year would save 3 ER visits to each hospital per day. Calculating 3 ER visits per day x $100 per visit x 116 hospitals x 365 days year results in a cost savings of approximately $12.7 Million per year.

It is important to note that limiting ER visits does not block access to the ER. Every person is still entitled to seek access. Taxpayers just will not foot the bill.

Proposal Number 2 – Limit Prescriptions to 5 Per Month.

Allow members 4 generic and 1 brand name prescription per month, regardless of age.

It is important to note that there are an increasing number of low cost formularies with an increasing number of drugs on those formularies, i.e. the Wal-Mart $4 list. This allows patients to obtain more and more medicines at an affordable cost. For the vast majority of pharmaceuticals, there is a generic alternative to the brand name that will accomplish the same purpose.

Proposal Number 3 – Eliminate Coverage of Controlled Substances

Narcotic over use and abuse is a major problem in this state, contributing to an increasing number of deaths by overdose, many accidental. Narcotic prescriptions are cheap and can be purchased at low cost for those truly in need. Dr. Cox closed by citing a couple of cases from his own experience to demonstrate examples of over use and abuse of ER visits and narcotics.

There was much discussion by the Board about the dispensing of narcotics, whether stopping SoonerCare funding would deter the abuse of narcotics and other ways that the OHCA might be of assistance in the prevention of narcotic abuse, including physician education about available tools. Paul Darden, a pediatrician from OU, commented that research from the 90's suggested that limiting prescriptions actually increased costs on the hospital and nursing home side, so that would need to be considered. Dr. Darden's other comment was that narcotics are not the only controlled substances, and that many of the other controlled substances are very expensive.

ITEM 6 / 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)

Howard Pallotta, Director of Legal Services and General Counsel

MOTION: Vice-Chairman Armstrong moved for Executive Session. Member McFall seconded.

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

BOARD MEMBERS ABSENT: Member Langenkamp

RECESS

RECONVENE BOARD MEETING/RETREAT 8:30 a.m. THURSDAY, AUGUST 25, 2011, HYATT REGENCY HOTEL, TULSA SOUTH AND CENTRAL BALLROOMS

THE FOLLOWING ITEMS WILL FOLLOW RETREAT FORMAT OF PANEL DISCUSSION AND OPEN DISCUSSION: ITEMS (7) THROUGH (18) ARE DISCUSSION ITEMS ONLY

Chairman Roggow reconvened the meeting at 8:47 a.m. and welcomed each of the attendees to OHCA's 12th Annual Board Retreat. He pointed out that, each person was given a packet upon registering which includes a flash drive with all of the presentations being made during the retreat. Chairman Roggow recognized the planning committee and thanked them for their efforts in putting together the retreat. He reflected that the first retreat was about 30 individuals sitting around a table talking about what changes were wanted, learning more as a Board and agency about the changes that were needed. Today, there are more than 200 people registered. Chairman Roggow stated that over the next two days, attendees would hear presentations, engage in conversations and build a plan of action that will move the OHCA forward. This is key as we are tasked with quickly implementing changes under the Affordable

Care Act. He encouraged all present to participate, be engaged, ask questions, learn more about the agency, to visit the Quality Team tables located in the lobby and to complete the surveys found on each table to help build an even better retreat in coming years.

CEO, Mike Fogarty introduced all of the board members present, and recognized several members of the legislature in attendance. He thanked all for being there and looked forward to a great retreat.

7. Session I – OHCA Overarching Goals and Agenda Highlights

Presenter – Cindy Roberts, Deputy CEO - Policy, Planning & Integrity, OHCA

Ms. Roberts reviewed the agency's mission, vision and six overarching goals, highlighted upcoming sessions during the retreat and described the relationship between the agency's goals and session topics for this year's strategic planning activities.

8. Session II – From Baby Boomers to Millennials…Perspectives on the Oklahoma Health Care System over the last 10, 15, 20 years

Moderator – Nico Gomez, Deputy CEO – Communications, Outreach & Reporting, OHCA

Panelists – Mike Fogarty, CEO, OHCA and George Miller, former Oklahoma State Senator, OHCA Board Member

During this session, panelists were asked to look back over their 75 years of combined state experience to give an overview of their experiences and perspectives as policy makers, how the program evolved and expanded, the role and influence Medicaid had on building state infrastructure and the shift to health care, not welfare. In conclusion, Member Miller advised the attendees to do everything in their power to make sure these programs continue and stated that 98% of the money spent in these programs goes into the Oklahoma economy. CEO, Fogarty encouraged all to stay true and committed to the agency's mission and vision, and to learn from history.

9. Session III – OHCA in the Spotlight – Local, State and National Attention on our Sooner State

Presenter – Nico Gomez, Deputy CEO – Communications, Outreach & Reporting, OHCA

During this session, Mr. Gomez highlighted innovative programs and practices of the OHCA, many of which are drawing a light of national attention and local praise. Many of these innovations originated in meetings like the board retreat and other committee meetings. This presents an opportunity, not only to reflect, but to be motivated knowing that the time spent here makes a difference for the future. Featured were programs such as Insure Oklahoma, Patient Centered Medical Home, Living Choice, Electronic Newborn Enrollment, SoonerEnroll, Online Enrollment, EHR Incentive Program and others.

10. Session IV – Medicaid Mandates from the Affordable Care Act – Looking back at program integrity requirements through the rear-view mirror

Moderator – Cindy Roberts, Deputy CEO – Policy, Planning & Integrity, OHCA

Panelists – Howard Pallotta, JD, General Counsel & Director of Legal Services, OHCA
Kelly Shropshire, CPA, Director of Program Integrity & Accountability, OHCA
Traylor Rains, JD, Policy Development Coordinator, Health Policy, OHCA

During this session, each panelist provided information on three particular ACA requirements that impact program integrity and policy. Mr. Pallotta discussed screening, revalidation and site visits of providers. Mr. Shropshire discussed payment suspension, recovery audit contractors and contract terminations for providers. Mr. Rains discussed policy changes to existing rules for hospice care for children, the recertification of adults in hospice and tobacco cessation for pregnant women. Oklahoma is ahead of the curve on many of the items discussed.

11. Session V – Medicaid Mandates from the Affordable Care Act – Setting our sites on the road ahead

Moderator – Buffy Heater, MPH, Director of Planning & Development, OHCA

Presenters – Tywanda Cox, Director of Policy, OHCA
Lynn Puckett, Director of Contractor Information Systems, OHCA
Carrie Evans, Chief Financial Officer, OHCA
Tanya Case, Executive Director, Oklahoma Temporary High Risk Pool

This session focused on plans for two of the biggest mandates from the Affordable Care Act. These are changes in eligibility criteria categorical to MAGI and Medicaid expansion and enrollment. All discussion and presentation was based on how the ACA will look in 2014 per the ACA as it exists today. The panelists gave an overview of how Medicaid populations look today versus how they will look in 2014, the policy changes that will be required, changes in CMS IT funding and system changes required for new eligibility criteria, the additional resources required – funding and staff, and talked about the positive impact to Oklahoma's economy. Panelists also talked about the Oklahoma Temporary High Risk Pool, which is a bridge until January 2014 when the new laws are to take effect. The session ended with much discussion and input on the ACA's potential impact on members, providers and agency partners. Chairman Roggow commented that, in light of all input, we must build a tighter coalition and move forward, starting immediately with a partnership to achieve cost savings for each agency.

12. Session VI – Oklahoma Health Information Initiatives – Explaining HIT, HIE, HIO, EHR…and the rest of the alphabet

Moderator – Garth L. Splinter, MD, State Medicaid Director, OHCA

Presenters – John Calabro, Oklahoma State HIT Coordinator
Adolph Maren, Jr., MA, Planning Project Manager, OHCA
Chad Sickler, EHR Incentive Program Coordinator, OHCA
Carter Kimble, Public Information Representative, OHCA

Presenters in this session provided insight on the exchange of health information records, defined and explained the different acronyms used to describe the processes, organizations and

entities. The EHR program and OHCA's role in administering it and plans for outreach and communication were discussed.

13. Session VII – Coordinating Care for Members Dually Eligible for Medicare and Medicaid – Exploring a new frontier

Moderator – Buffy Heater, MPH, Director of Planning & Development, OHCA

Panelists – Garth L. Splinter, MD State Medicaid Director, OHCA
Von Lawson, Director of Opportunities for Living Life, OHCA
Gerry Clancy, MD, President of OUHSC – Tulsa Campus
Marva Crawford Williamson, Dual Eligible Project Coordinator, OHCA

This session focused on members dually eligible for Medicare and Medicaid, what that means, how care will be coordinated and federal initiatives for these populations, as well as, education of health care staff, the PACE program and creating solutions that improve services.

14. Session VIII – Last Call – Questions & Answers

Facilitator – Nico Gomez, Deputy CEO – Communications, Outreach & Reporting, OHCA

Mr. Gomez took the opportunity to thank HP Services for providing the flash drives and gave an overview of Friday's agenda.

RECESS

RECONVENE BOARD MEETING/RETREAT 8:30 a.m., FRIDAY, AUGUST 26, 2011
HYATT REGENCY HOTEL, TULSA SOUTH AND CENTRAL BALLROOMS

THE FOLLOWING ITEMS WILL FOLLOW RETREAT FORMAT OF PANEL DISCUSSION AND OPEN DISCUSSION: ITEMS (7) THROUGH (18) ARE DISCUSSION ITEMS ONLY

Chairman Roggow reconvened the meeting/retreat at 8:39 a.m. and encouraged attendees to engage and ask questions.

15. Session IX – OHCA Advisory Boards and Committees

Moderators:

Terrie Fritz, External Relations Coordinator, OHCA
Carter Kimble, Public Information Representative, OHCA
J. Paul Keenan, MD, Chief Medical Officer, OHCA

OHCA Advisory Committees

Behavioral Health Advisory Committee
Child Health Advisory Task Force
Dental Focus Group
Drug Utilization Review Board

Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Advisory Committee
Focus on Excellence Advisory Committee
Living Choice Advisory Committee
Medical Advisory Committee
Medical Advisory Task Force
Perinatal Advisory Task Force

This session centered on the advisory committees and task forces that provide stakeholder input and guidance on the agency's programs, both current and with the future in mind. Attendees heard from members of several of these committees and task forces, and learned more initiatives that each group is undertaking, how lives have been impacted by participation and ideas for future growth.

16. Session X – OHCA Quality Initiatives – Gaining valuable efficiencies

(Panel One) All Things Care Management

Moderator – Marlene Asmussen, RN, CCM, Director of Care Management and Medical Authorization Services, OHCA

Presenters – Carolyn Reconnu, RN, CCM, Health Management Manager, OHCA
Rebekah Gossett, RN, Care Management Supervisor, OHCA
Debbie Spaeth, LMFT, Behavioral Health Services Director, OHCA

(Panel Two) Management of Emergency Room and Radiology Services Use

Moderator – Becky Pasternik-Ikard, JD, RN, Director of SoonerCare Operations, OHCA

Presenters – Melody Anthony, Director of Provider Services, OHCA
Kevin Rupe, Director of Member Services, OHCA
Ken Goodwin, RN, Medical Authorization Manager, OHCA

Presenters in this session talked about current, on-going agency initiatives designed to improve access to care, encourage personal responsibility and promote cost-savings and increased efficiencies. Some of the initiatives highlighted were the SoonerCare Health Management Program, Targeted Pregnancy Program to reduce infant mortality & encourage healthy moms and babies, Care Management Oversight Project, ER Utilization Project and the Radiology Management Medicine Program.

17. Session XI – Last Call / Open Forum / Action Plan Review

Facilitator – Nico Gomez, Deputy CEO – Communications, Outreach and Reporting, OHCA

There were various questions and suggestions raised from attendees of the board retreat which were answered by panelists, board members and distinguished guests. During the entirety of the retreat questions, observations and suggestions have been recorded for use as the agency moves forward with planning for the future.

The entire audio recordings of the Board meeting/retreat are available on the OHCA website.

18. Wrap-up / Closing Remarks

Chairman Roggow thanked everyone for their attendance and participation in helping us move forward for the citizens of Oklahoma.

ITEM 19 / NEW BUSINESS

None.

ITEM 20 / ADJOURNMENT

MOTION:	Vice-Chairman Armstrong moved for adjournment. Member McFall seconded.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Bryant, Member Miller, Member McFall, Chairman Roggow
BOARD MEMBERS ABSENT:	Member Langenkamp Member McVay

FINANCIAL REPORT

For the Two Months Ended August 31, 2011
Submitted to the CEO & Board
October 13, 2011

- Revenues for OHCA through August, accounting for receivables, were **$663,274,776** or **(.3%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$587,296,016** or **.9% under** budget.
- The state dollar budget variance through August is **$3,993,769 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		0.2
Administration		1.1
Revenues:		
Taxes and Fees		.9
Drug Rebate		.6
Overpayments/Settlements		1.2
Total FY 12 Variance	**$**	**4.0**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2012, For the Two Months Ended August 31, 2011

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 199,134,051	$ 199,134,051	$ -	0.0%
Federal Funds	356,696,188	348,566,954	(8,129,235)	(2.3)%
Tobacco Tax Collections	9,624,409	10,663,036	1,038,627	10.8%
Quality of Care Collections	8,625,155	8,531,054	(94,101)	(1.1)%
Prior Year Carryover	45,003,490	45,003,490	-	0.0%
Federal Deferral - Interest	54,936	54,936	-	0.0%
Drug Rebates	35,257,543	37,094,578	1,837,035	5.2%
Medical Refunds	6,725,146	10,576,481	3,851,335	57.3%
Other Revenues	3,958,307	3,970,506	12,198	0.3%
TOTAL REVENUES	**$ 665,079,226**	**$ 663,595,086**	**$ (1,484,141)**	**(0.2)%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 7,268,473**	**$ 6,445,249**	**$ 823,224**	**11.3%**
ADMINISTRATION - CONTRACTS	**$ 17,316,660**	**$ 15,713,847**	**$ 1,602,813**	**9.3%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	5,722,900	4,928,753	794,147	13.9%
Acute Fee for Service Payments:				
Hospital Services	152,343,442	149,910,185	2,433,258	1.6%
Behavioral Health	51,213,787	54,657,691	(3,443,903)	(6.7)%
Physicians	73,394,984	71,194,381	2,200,603	3.0%
Dentists	25,745,616	26,384,504	(638,889)	(2.5)%
Other Practitioners	10,355,185	12,213,454	(1,858,269)	(17.9)%
Home Health Care	3,916,191	3,584,669	331,521	8.5%
Lab & Radiology	8,628,569	9,123,103	(494,534)	(5.7)%
Medical Supplies	8,178,614	7,743,710	434,905	5.3%
Ambulatory Clinics	15,549,186	14,057,758	1,491,427	9.6%
Prescription Drugs	60,720,987	58,785,883	1,935,104	3.2%
Miscellaneous Medical Payments	5,452,222	5,708,198	(255,976)	(4.7)%
OHCA TFC	-	539,124	(539,124)	0.0%
Other Payments:				
Nursing Facilities	84,574,666	84,428,863	145,803	0.2%
ICF-MR Private	9,691,716	9,673,510	18,206	0.2%
Medicare Buy-In	23,926,209	23,704,164	222,045	0.9%
Transportation	4,654,777	4,560,887	93,890	2.0%
EHR-Incentive Payments	11,925,766	11,925,766	-	0.0%
Part D Phase-In Contribution	12,104,595	12,012,317	92,277	0.8%
Total OHCA Medical Programs	**568,099,410**	**565,136,920**	**2,962,491**	**0.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 592,773,925**	**$ 587,296,016**	**$ 5,477,910**	**0.9%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 72,305,301**	**$ 76,299,070**	**$ 3,993,769**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2012, For the Two Months Ended August 31, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 5,002,928	$ 4,925,249	$ -	$ 74,175	$ -	$ 3,505	$ -
Inpatient Acute Care	112,228,618	100,501,924	81,114	2,066,311	8,385,938	542,773	650,557
Outpatient Acute Care	42,126,053	39,455,817	6,934	1,727,618	-	935,683	
Behavioral Health - Inpatient	20,070,920	19,717,526	-	-	-	2,658	350,735
Behavioral Health - Outpatient	2,276,478	2,269,388	-	-	-	-	7,091
Behavioral Health Facility- Rehab	38,006,065	32,641,281	-	86,423	-	26,838	5,251,523
Behavioral Health - Case Management	-	-	-	-	-	-	
Residential Behavioral Management	2,644,477	-	-	-	-	-	2,644,477
Targeted Case Management	10,786,972	-	-	-	-	-	10,786,972
Therapeutic Foster Care	539,124	539,124	-	-	-	-	-
Physicians	80,214,002	59,301,133	9,683	2,858,740	10,219,978	1,663,586	6,160,881
Dentists	26,398,339	25,038,780	-	13,835	1,330,772	14,952	-
Other Practitioners	12,307,060	11,967,582	74,394	93,606	163,056	8,422	-
Home Health Care	3,584,669	3,576,232	-	-	-	8,437	-
Lab & Radiology	9,665,609	8,869,526	-	542,506	-	253,577	-
Medical Supplies	7,871,786	7,319,710	412,658	128,076	-	11,342	-
Ambulatory Clinics	15,169,096	13,987,448	-	305,726	-	70,310	805,612
Personal Care Services	2,139,226	-	-	-	-	-	2,139,226
Nursing Facilities	84,428,863	54,207,339	23,391,641	-	6,822,028	7,855	-
Transportation	4,560,887	4,121,487	427,200	-	11,009	1,191	-
GME/IME/DME	22,749,308	-	-	-	-	-	22,749,308
ICF/MR Private	9,673,510	7,961,486	1,570,542	-	141,482	-	-
ICF/MR Public	9,723,289	-	-	-	-	-	9,723,289
CMS Payments	35,716,481	35,284,371	432,111	-	-	-	-
Prescription Drugs	61,765,411	51,242,068	-	2,979,529	7,169,649	374,166	-
Miscellaneous Medical Payments	5,708,249	5,451,895	-	51	237,250	19,053	-
Home and Community Based Waiver	27,049,690	-	-	-	-	-	27,049,690
Homeward Bound Waiver	15,055,551	-	-	-	-	-	15,055,551
Money Follows the Person	518,501	-	-	-	-	-	518,501
In-Home Support Waiver	4,165,233	-	-	-	-	-	4,165,233
ADvantage Waiver	30,572,745	-	-	-	-	-	30,572,745
Family Planning/Family Planning Waiver	1,165,910	-	-	-	-	-	1,165,910
Premium Assistance*	10,445,899	-	-	10,445,899	-	-	-
EHR Incentive Payments	11,925,766	11,925,766					
Total Medicaid Expenditures	**$ 726,256,716**	**$ 500,305,132**	**$ 26,406,278**	**$ 21,322,496**	**$ 34,481,161**	**$ 3,944,349**	**$ 139,797,300**

* Includes $10,389,270 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2012, For the Two Months Ended August 31, 2011

		FY12
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	37,929,558
Federal Funds		91,191,208
TOTAL REVENUES	**$**	**129,120,766**

EXPENDITURES	**Actual YTD**
Department of Human Services	
Home and Community Based Waiver	$ 27,049,690
Money Follows the Person	518,501
Homeward Bound Waiver	15,055,551
In-Home Support Waivers	4,165,233
ADvantage Waiver	30,572,745
ICF/MR Public	9,723,289
Personal Care	2,139,226
Residential Behavioral Management	2,145,147
Targeted Case Management	8,625,187
Total Department of Human Services	**99,994,568**
State Employees Physician Payment	
Physician Payments	6,160,881
Total State Employees Physician Payment	**6,160,881**
Education Payments	
Graduate Medical Education	3,850,000
Graduate Medical Education - PMTC	-
Indirect Medical Education	14,838,825
Direct Medical Education	4,060,483
Total Education Payments	**22,749,308**
Office of Juvenile Affairs	
Targeted Case Management	401,848
Residential Behavioral Management - Foster Care	7,659
Residential Behavioral Management	491,671
Multi-Systemic Therapy	7,091
Total Office of Juvenile Affairs	**908,269**
Department of Mental Health	
Targeted Case Management	-
Hospital	350,735
Mental Health Clinics	5,251,523
Total Department of Mental Health	**5,602,259**
State Department of Health	
Children's First	368,372
Sooner Start	319,237
Early Intervention	957,108
EPSDT Clinic	312,519
Family Planning	8,596
Family Planning Waiver	1,148,436
Maternity Clinic	28,736
Total Department of Health	**3,143,005**
County Health Departments	
EPSDT Clinic	145,119
Family Planning Waiver	8,877
Total County Health Departments	**153,996**
State Department of Education	**23,222**
Public Schools	**411,235**
Medicare DRG Limit	**-**
Native American Tribal Agreements	**-**
Department of Corrections	**-**
JD McCarty	**650,557**
Total OSA Medicaid Programs	**$ 139,797,300**
OSA Non-Medicaid Programs	**$ 13,133,988**
Accounts Receivable from OSA	**$ 23,810,522**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2012, For the Two Months Ended August 31, 2011

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 8,487,347	$ 8,487,347
Interest Earned	43,707	43,707
TOTAL REVENUES	**$ 8,531,054**	**$ 8,531,054**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 22,761,660	$ 7,980,238	
Eyeglasses and Dentures	49,661	17,411	
Personal Allowance Increase	580,320	203,460	
Coverage for DME and supplies	412,658	144,678	
Coverage of QMB's	172,126	60,347	
Part D Phase-In	432,111	432,111	
ICF/MR Rate Adjustment	829,912	290,967	
Acute/MR Adjustments	740,630	259,665	
NET - Soonerride	427,200	149,776	
Total Program Costs	**$ 26,406,278**	**$ 9,538,654**	**$ 9,538,654**
Administration			
OHCA Administration Costs	$ 555,990	$ 277,995	
DHS - 10 Regional Ombudsman	242,662	242,662	
OSDH-NF Inspectors	358,163	358,163	
Mike Fine, CPA	20,000	10,000	
Total Administration Costs	**$ 1,176,815**	**$ 888,820**	**$ 888,820**
Total Quality of Care Fee Costs	**$ 27,583,092**	**$ 10,427,473**	
TOTAL STATE SHARE OF COSTS			**$ 10,427,473**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2012, For the Two Months Ended August 31, 2011

REVENUES	FY 11 Carryover	FY 12 Revenue	Total Revenue
Prior Year Balance	$ 8,067,432	$ -	$ 16,176,756
State Appropriations			
Tobacco Tax Collections	-	8,770,024	8,770,024
Interest Income	-	79,219	79,219
Federal Draws	281,502	10,298,434	10,298,434
All Kids Act	7,870,437	129,563	129,563
TOTAL REVENUES	$ 16,219,371	$ 19,277,241	$ 35,324,434

EXPENDITURES		FY 11 Expenditures	FY 12 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 10,266,129	$ 10,266,129
	College Students		56,630	56,630
	All Kids Act		123,140	123,140
Individual Plan				
	SoonerCare Choice		$ 72,207	$ 25,316
	Inpatient Hospital		2,053,079	719,809
	Outpatient Hospital		1,704,939	597,752
	BH - Inpatient Services		-	-
	BH Facility - Rehabilitation Services		85,605	30,013
	Physicians		2,845,808	997,740
	Dentists		10,781	3,780
	Other Practitioners		89,925	31,528
	Home Health		-	-
	Lab and Radiology		534,829	187,511
	Medical Supplies		126,822	44,464
	Ambulatory Clinics		302,374	106,012
	Prescription Drugs		2,936,995	1,029,710
	Miscellaneous Medical		-	-
	Premiums Collected		-	409,710
Total Individual Plan			$ 10,763,364	$ 4,183,345
	College Students-Service Costs		$ 94,913	$ 33,276
	All Kids Act- Service Costs		$ 18,320	$ 6,423
Total Program Costs			$ 21,322,496	$ 14,668,944
Administrative Costs				
	Salaries	$ 13,534	$ 267,855	$ 281,389
	Operating Costs	29,081	13,489	42,570
	Health Dept-Postponing	-	-	-
	Contract - HP	-	-	-
Total Administrative Costs		$ 42,615	$ 281,344	$ 323,959
Total Expenditures				$ 14,992,903
NET CASH BALANCE		$ 16,176,756		$ 20,331,531

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2012, For the Two Months Ended August 31, 2011

REVENUES	FY 12 Revenue	State Share
Tobacco Tax Collections	**$ 175,021**	**$ 175,021**
TOTAL REVENUES	**$ 175,021**	**$ 175,021**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 3,505	$ 860	
Inpatient Hospital	542,773	133,197	
Outpatient Hospital	935,683	229,617	
Inpatient Free Standing	2,658	652	
MH Facility Rehab	26,838	6,586	
Case Mangement	0	-	
Nursing Facility	7,855	1,928	
Physicians	1,663,586	408,244	
Dentists	14,952	3,669	
Other Practitioners	8,422	2,067	
Home Health	8,437	2,071	
Lab & Radiology	253,577	62,228	
Medical Supplies	11,342	2,783	
Ambulatory Clinics	70,310	17,254	
Prescription Drugs	374,166	91,820	
Transportation	1,191	292	
Miscellaneous Medical	19,053	4,676	
Total Program Costs	$ 3,944,349	$ 967,943	**$ 967,943**
TOTAL STATE SHARE OF COSTS			**$ 967,943**

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

SoonerCare Programs

August 2011 Data for October 2011 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2011	Enrollment August 2011	Total Expenditures August 2011	Average Dollars Per Member Per Month August 2011
SoonerCare Choice Patient-Centered Medical Home		448,831	**447,916**	**$143,165,351**	
	Lower Cost (Children/Parents; Other)		402,475	$97,136,933	$241
	Higher Cost (Aged, Blind or Disabled; TEFRA; BCC)		45,441	$46,028,418	$1,013
SoonerCare Traditional		240,078	**246,569**	**$244,836,582**	
	Lower Cost (Children/Parents; Other)		140,283	$92,764,704	$661
	Higher Cost (Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)		106,286	$152,071,878	$1,431
SoonerPlan		32,050	**38,800**	**$792,238**	$20
Insure Oklahoma		32,205	**32,272**	**$10,941,747**	
	Employer-Sponsored Insurance	19,003	18,315	$4,585,355	$250
	Individual Plan	13,202	13,957	$6,356,392	$455
TOTAL		**753,163**	**765,557**	**$399,735,917**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $23,121,707 are excluded.

Net Enrollee Count Change from Previous Month Total	**9,969**

New Enrollees	**23,824**

Opportunities for Living Life (OLL) (subset of data above)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,892
Aged/Blind/Disabled	*Adult*	130,586
Other	*Child*	156
Other	*Adult*	20,074
PACE	*Adult*	81
TEFRA	*Child*	397
Living Choice	*Adult*	113
OLL Enrollment		**171,299**

The "Other" category includes DDSD State, PKU, Q1, Q2, Refugee, SLMB, Soon-to-be-Sooners (STBS) and TB members.

Medicare and SoonerCare	Monthly Average SFY2011	Enrolled August 2011
Dual Enrollees	**103,906**	**105,964**

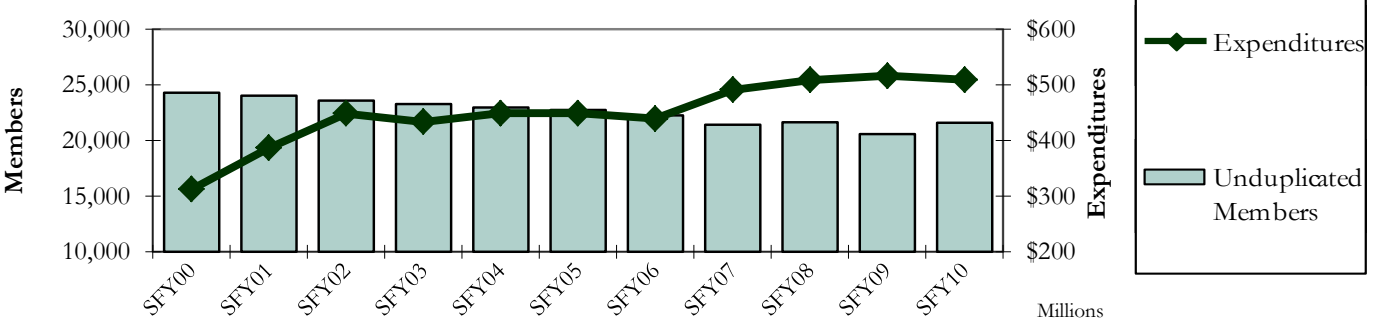
		Monthly Average SFY2011	Enrolled August 2011	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,809**	**$3,799**
	Child	92	102	
	Adult	15,641	15,707	

SFY2010 Long-Term Care

Statewide LTC Occupancy Rate - 69.8%
SoonerCare funded LTC Bed Days 68.6%

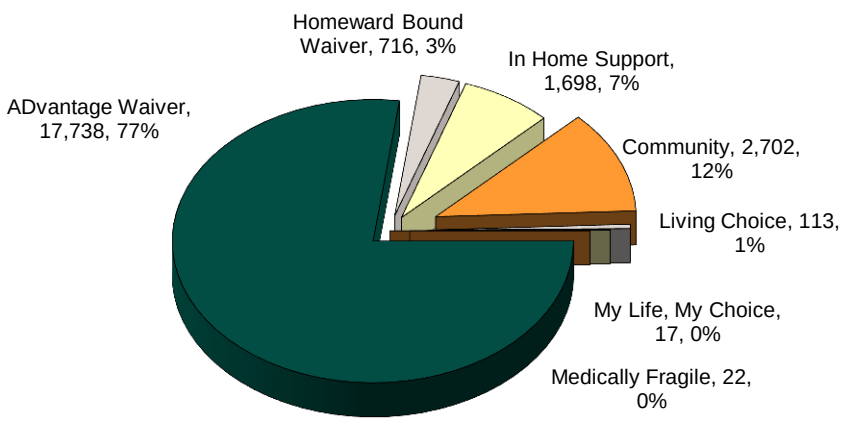
Data as of September 2010

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).

Waiver Enrollment Breakdown Percent



ADvantage Waiver - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.
Community - serves individuals 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded/intellectually disabled (ICF/MR).
Homeward Bound Waiver - Designed to serve the needs of individuals with intellectual disabilities or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/MR.
In Home Support - Serves the needs of individuals 3 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/MR.
Living Choice - Promotes community living for people of all ages who have disabilities or long-term illnesses.
Medically Fragile - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.
My Life, My Choice - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2011	Enrolled August 2011
Total Providers		**29,026**	**33,318**
	In-State	20,585	22,056
	Out-of-State	8,442	11,262

Program	% of Capacity Used
SoonerCare Choice	40%
SoonerCare Choice I/T/U	12%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled August 2011***	Total Monthly Average SFY2011	Total Enrolled August 2011
Physician	*6,489*	*7,155*	*11,777*	14,739
Pharmacy	*901*	*866*	*1,230*	1,134
Mental Health Provider	*935*	*978*	*982*	1,023
Dentist	*798*	*932*	*901*	1,050
Hospital	*187*	*190*	*739*	856
Licensed Behavioral Health Practitioner	*503*	*611*	*524*	642
Extended Care Facility	*392*	*391*	392	391

*The In-State Monthly Averages above were recalculated due to a change in the original methodology.

Total Primary Care Providers	*4,461*	*4,956*	6,467	7,176
Patient-Centered Medical Home	*1,476*	*1,525*	1,502	1,554

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

**Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

	August 2011		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	128	$2,720,000	828	$17,694,167
Eligible Hospitals	10*	$8,828,697	43	$31,852,490
Totals	138	$11,548,697	871	$49,546,657

*Current Eligible Hospitals Paid

ATOKA MEMORIAL HOSPITAL
CHOCTAW NATION - TALIHINA
ELKVIEW GEN HSP
MEDICAL CENTER HOSPITALS
MEMORIAL HOSPITAL & PHYSICIAN GROUP
MUSKOGEE REGIONAL MEDICAL CENTER
NEWMAN MEMORIAL HSP
PRAGUE COMMUNITY HOSPITAL
SEQUOYAH COUNTY CITY OF SALLISAW HOSPITAL AUTHORIT
SOUTHWESTERN MEDICAL CENT

OKLAHOMA HEALTH CARE AUTHORITY
SFY 2013
Budget Request Detail

Description of Priority	# FTE	State	Total
1 Annualizations			
FFP Match Rate 63.88% to 63.77% eff. 10/1/12		5,583,688	-
Medicare A & B Premiums/Deductible incr. for dual eligibiles eff. 1/1/12		1,095,128	3,039,490
	-	**6,678,817**	**3,039,490**
2 Maintenance			
FY13 growth/utilization increases (4.5%)		45,587,376	133,713,096
Medicare Physician Fee Schedule Rebase		6,485,400	18,000,000
Medicare A & B premiums		598,174	1,661,595
Medicare Part D (clawback)		1,011,589	1,011,589
Medicaid Inflationary contract increases		1,125,196	2,874,930
HIT Provider incentive Payments & meaningful use	3.0	480,000	4,800,000
SoonerRide (NET)		325,000	650,000
IT equipment for new building		653,024	1,423,660
Claim amt for two (1 week cycles)		47,828,716	133,869,132
FTE maintenance for growth in Medicaid Program	15.0	685,938	1,489,487
	18.0	**104,780,412**	**299,493,490**
3 One-Time Funding			
FY-11 one-time Carryover & Replace		55,003,490	-
	-	**55,003,490**	**-**
4 Mandates			
Afforable Care Act (ACA)			
System Changes		212,500	850,000
Physician Rate to 100% of Medicare Fee Schedule		751,674	2,087,984
FTE Request	26.0	524,056	1,048,112
	26.0	**1,488,230**	**3,986,095**
5 Restoration of Provider Rates			
Inpatient Hosp (PRTF's)		1,527,232	4,238,779
Inpatient Hosp DRG		7,171,359	19,903,856
Outpatient Hosp		2,394,607	6,646,147
Nursing Facilities		10,008,874	27,779,279
ICF/MR's		1,207,091	3,350,238
SoonerChoice Care Management (3.25%)		265,866	737,903
Physician fee schedule (Medicare RVU rebasing)		4,358,024	12,095,544
Other Practitioner		988,664	2,744,003
Home Health		164,765	457,299
Clinic Services (new FQHCs, RHCs, Family Planning and ESRD)		1,065,301	2,956,704
Lab		438,581	1,217,265
Anesthesiologist ($31.50 conversion factor)		327,869	909,988
Dental		1,551,923	4,307,308
Ambulance		206,092	572,000
Durable Medical Equipment		640,368	1,777,320
Behavioral Health Rehab		869,350	2,412,851
	-	**33,185,966**	**92,106,484**
6 Provider Rate Maintenance			
Nursing Facilities		10,836,418	30,101,162
ICF/MR's		577,343	1,603,730
Private Duty Nurses (61% inc)		1,597,466	4,437,406
Lab		202,016	561,155
Anesthesiologist ($39.40 CF/25%inc)		1,205,293	3,348,037
Ambulance		1,449,507	4,026,407
	-	**15,868,043**	**44,077,897**
7 FTE - Online Enrollment	**13.0**	**502,163**	**1,004,325**
8 Health Information Technology (Staffing & Equipment)	**1.0**	**102,168**	**158,328**
9 Behavioral Health Screenings	**-**	**286,044**	**793,905**
10 Program Integrity Review Team	**10.0**	**(181,972)**	**(824,896)**

OKLAHOMA HEALTH CARE AUTHORITY
SFY 2013
Budget Request Detail

Description of Priority	# FTE	State	Total
11 CMS Psychiatric Emergency Demonstration Grant	1.0	1,395,184	13,951,842
12 3 FTE - Insure Oklahoma	3.0	-	204,924
13 Expand coverage of DME services	-	72,060	200,000
14 1 FTE - DME Reuse Program	1.0	29,252	58,504
15 Primary Care Medical Home Evaluation		125,000	250,000
16 LBHP Testing for Adults		19,817	55,000
17 2 FTE - SoonerCare Operations	2.0	40,958	(583)
18 3 FTE - OLL Carl Albert Interns	3.0	-	-
19 Substance Abuse Residential Treatment for Children		1,152,360	3,201,000
20 1 FTE - IS Helpdesk	1.0	41,979	83,958
21 Provider Credentialing	1.0	34,163	68,326
22 BRCA Gene Testing		810,675	2,250,000
23 Adult Behavioral Health Co-Pay reduction		58,355	161,962
24 Medication Therapy Management		275,000	550,000
25 2 FTE - Performance & Reporting	2.0	75,633	151,265
26 Children's Behavioral Health Systems of Care		64,854	180,000
27 Psychologist/LBHP Adult Therapy		252,411	700,557
28 Preventive MedCounseling		200,000	400,000
29 Insulin/Immunosuppresents		701,144	2,780,000
30 Substance Abuse Residential Treatment for Adults		768,088	2,131,800
31 1 FTE - Medical Physician	1.0	49,533	198,134
32 Hepatitis B Vaccinations		288,240	800,000
33 4 FTE - CMHC Health Homes	4.0	89,302	292,564
FY-2012 Budget Request Priorities	**87.0**	**224,257,368**	**472,504,371**

8.b-1 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Waiver Program Services
OAC 317:30-5-763. [AMENDED]
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 17. ADvantage Waiver Services
OAC 317:30-5-763. [AMENDED]
(Reference APA WF # 11-11 A & B)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rules to remove certain covered benefits from the ADvantage Waiver Program in order to comply with the revisions in operational procedures currently approved by the Centers for Medicare and Medicaid Services (CMS) in Oklahoma's 1915(c) Home and Community Based Services Waiver. Failure to make these changes would put the Agency's rules out of compliance with current Federal approvals thereby placing the Agency's Federal Financial Participation (FFP) for ADvantage Waiver Services at risk.

ANALYSIS: OHCA rules for the ADvantage Waiver program are revised to remove respiratory therapy as an allowable service within the waiver and remove Hospice when the member is in a nursing facility receiving ADvantage Facility Based Extended Respite. Both services are removed due to lack of utilization. Additionally, rules are revised to remove language allowing for reimbursement to providers of case management transition services when the member fails to transition into the ADvantage waiver program. The revisions are necessary to align OHCA policy with revised operational procedures as approved by the Centers for Medicare and Medicaid Services (CMS).

BUDGET IMPACT: Agency staff has determined that these revisions will result in an estimated savings of $15,000 which will be realized by Oklahoma Department of Human Services who operates the Program.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 15, 2011 and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1915(C) of the Social Security Act pertaining to Home and Community Based Services waivers as approved by the Centers for Medicare and Medicaid Services (CMS).

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

Revise ADvantage Waiver Program rules by removing respiratory therapy and hospice when the member is in a nursing facility receiving ADvantage Facility Based Extended Respite as allowable services within the ADvantage program as well as removing language allowing reimbursement for case management for transitioning services when the member fails to transition into the ADvantage Waiver Program.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) **Case Management.**

(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~~ 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~~ 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)~~ (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. 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.

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

~~(14)~~ (13) **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)~~ (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 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)~~ (15) **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)~~ (16) **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~~ not reimbursable.

~~(18)~~ (17) **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 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to

arrest the deterioration. ADvantage program members must be SoonerCare eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage Assisted Living Center. The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have mental retardation or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet the following criteria:

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see OAC 317:35-17-3(d)]; and

(C) meet program eligibility criteria [see OAC 317:35-17-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap.

(c) Services provided through the ADvantage waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy/occupational therapy/~~respiratory therapy/~~speech therapy or consultation;

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

(11) medically necessary prescription drugs within the limits of the waiver;

(12) personal care (state plan) or ADvantage personal care;

(13) Personal Emergency Response System (PERS);

(14) Consumer-Directed Personal Assistance Services and Supports

(CD-PASS);
(15) Institution Transition Services;
(16) assisted living; and
(17) SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

(d) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the individual. If the OKDHS/ASD determines all ADvantage waiver slots are filled, the individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the individual's name is placed on a waiting list for entry as an open slot becomes available. ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for persons that have a developmental disability and those that do not have a developmental disability.

(2) the individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have mental retardation or a cognitive impairment.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(e) The OKDHS/ASD determines ADvantage program eligibility through the service plan approval process. The following criteria are used to make the ADvantage program eligibility determination that an individual is not eligible:

(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver individual's health, safety, or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan
services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require ADvantage services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual's health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OKDHS/ASD.

(f) The case manager provides the OKDHS/ASD with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the OKDHS/ASD will provide technical assistance to the Provider for transitioning the individual to other services.
(g) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

8.b-2 CHAPTER 2. GRIEVANCE PROCEDURE AND PROCESS
Subchapter 1. Rules
OAC 317:2-1-2. [AMENDED]
OAC 317:2-1-15. [NEW]
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
OAC 317:30-5-58. [NEW]
(Reference APA WF # 11-18 A & B)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rules to create guidelines for and implement the Supplemental Hospital Offset Payment Program (SHOPP) in order to avoid violation of 63 Okla. Stat. §§ 3241.1 through 3241.6.

ANALYSIS: Rules are revised to establish guidelines for and implement the Supplemental Hospital Offset Payment Program (SHOPP) as authorized by 63 Okla. Stat. §§ 3241.1 through 3241.6. OHCA is required by the SHOPP Act to assess all in-state hospitals, unless specifically exempted, an assessment fee of 2.5%. Funds derived from the assessment will be used to garner federal matching funds which will be used to maintain SoonerCare provider reimbursement rates as well as pay participating hospitals a quarterly access payment.

BUDGET IMPACT: Agency staff has determined that the assessment is expected to generate approximately $151 million in state dollars, $30 million of which is allocated to the Medical Payments Cash Management Improvement Act Program Disbursing Fund and used to maintain SoonerCare provider reimbursement rates. After garnering federal matching dollars, $336 million will be available to make supplemental payments to participating hospitals in the state of Oklahoma and approximately $83 million will be available to maintain SoonerCare provider payments.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 15, 2011 and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Sections 3241.1 through 3241.6 of Title 63 of the Oklahoma Statute and 42 CFR 433.68

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Agency rules to establish guidelines for and implement the Supplemental Hospital Offset Payment Program (SHOPP) as authorized by 63 Okla. Stat. §§ 3241.1 through 3241.6.

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
SUBCHAPTER 1. RULES

317:2-1-2. Appeals

(a) **Member Process Overview.**

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

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

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 ~~O.S. '~~ Okla. Stat. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

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

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

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 C.F.R. Section 431.244(f)]

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

(b) **Provider Process Overview.**

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

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

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

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

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

(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

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

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(F) Proposed administrative sanction appeals pursuant to 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(G) Appeals which relate to eligibility determinations made by OHCA;

(H) Appeals of insureds participating in Insure Oklahoma which are authorized by 317:45-9-8(a); and

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

(D) Petitions for Rulemaking;

(E) Appeals to the decision made by the Contracts manager related to reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;

(F) Drug rebate appeals;

(G) Nursing home contracts which are terminated, denied, or non-renewed;

(H) Proposed administrative sanction appeals pursuant to 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the

ALJ. This is the final and only appeals process for proposed administrative sanctions;
(I) Contract award appeals;
(J) Provider appeals of OHCA audit findings pursuant to 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and
(K) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives.
(L) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.

317:2-1-15. Supplemental Hospital Offset Payment Program (SHOPP) Appeals.

(a) In accordance with Title 63 of the Oklahoma Statutes Section 3241.4 OHCA is authorized to promulgate rules for appeals of annual assessments, fees and penalties to hospitals as defined by the statute. The rules in this Section describe those appeals rights.

(1) OAC 317:30-5-58 subsections (a) through (e) describe the SHOPP Assessments, fees and the penalties for non-payment of the fee or failure to file a cost report, as set out in 63 Okla. Stat. §§ 3241.3 and 3241.4

(2) Appeals filed under this Section are heard by an Administrative Law Judge (ALJ).

(3) To file an appeal, the provider hospital must file an LD-2 form within thirty (30) days of receipt of the notification from OHCA assessing the annual SHOPP Assessment, a fee or penalty. The penalty, fee or assessment is deducted from the hospital's payment if the assessment is unpaid at the time the appeal is filed. If the hospital prevails in the appeal the amount assessed will be returned to the hospital with their payment.

(4) The hearing will be conducted in accordance with OAC 317:2-1-5.

(b) An individual hospital may appeal an individual assessment at the time of its annual assessment. As provided for above in subsection (3), the appeal must be filed within thirty (30) days of receipt of the notification of assessment by OHCA to the hospital. If the hospital challenges the computation of the hospital's net patient revenue, the assessment rate, or assessment amount then the appeal will proceed in accordance with subsection(4)above.

(c) Individual hospitals that appeal the quarterly assessment are limited to calculation errors in dividing the annual assessment into four (4) parts. Appeals must be filed within thirty 30 days of receipt of the notice of assessment by OHCA to the hospital. The appeal will proceed in accordance with subsection (4) above.

(d) If OHCA determines an overpayment of SHOPP payments has been made to an individual hospital, then the hospital may file an appeal within thirty (30) days of the notice of overpayment. Overpayments are deducted from the hospital's payment. The appeal will proceed in accordance with subsection (4) above.

(e) OHCA recognizes that some individual hospital's claims regarding an inappropriate assessment or overpayment may involve aggregate data. For example an appeal may involve one of the following issues:

(1) total hospitals in the entire SHOPP pool;
(2) total hospitals that are exempt from SHOPP;
(3) total hospitals classified as critical access hospitals;
(4) total net revenue from all hospitals in the pool;
(5) the total amount of monies allocated to each pool in the SHOPP; or
(6) the pro-rata distribution in a pool(s),

(f) If an individual hospital brings an aggregate appeals claim, there are two (2) elements of proof to be met. The ALJ must determine that the hospital can demonstrate by a preponderance of evidence:
(1) that data was made available before the hospital submitted the appeal; and
(2) a specific calculation error has been made statewide that can be shown by the hospital.

(g) The "Upper Payment Limit" and the "Upper Payment limit Gap" are not appealable in the administrative process.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-58. Supplemental Hospital Offset Payment Program

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes.

(b) **Definitions.** The following words and terms, when used in this Section have the following meaning, unless the context clearly indicates otherwise:
(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care Authority (OHCA) if the hospital's data is not included in a Medicare Cost Report.
(2) **"Fee"** means supplemental hospital offset assessment pursuant to Section 3241.1 of Title 63 of the Oklahoma Statutes.
(3) **"Hospital"** means an institution licensed by the State Department of Health as a hospital pursuant to Section 1-701.1 of Title 63 of the Oklahoma Statutes maintained primarily for the diagnosis, treatment, or care of patients;
(4) **"Hospital Advisory Committee"** means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.
(5) **"NET hospital patient revenue"** means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines 16, 17 and 18) of the Medicare Cost Report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)and Worksheet G-2 (Part I, Column 3, Line 25);
(6) **"Medicare Cost Report"** means form CMS-2552-96, the Hospital Cost Report, as it existed on January 1, 2011;
(7) **"Upper payment limit"** means the maximum ceiling imposed by 42 C F R §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and outpatient services, other than to hospitals owned or operated by state government; and

(8) **"Upper payment limit gap"** means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to 63 Okla. Stat. §§ 3241.1 through 3241.6 the Oklahoma Health Care Authority (OHCA) was mandated to assess hospitals licensed in Oklahoma, unless exempted under (c) (2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

(A) a hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicaid and State operations.

(B) a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C) a hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, using the Inpatient Discharge Data File published by the Oklahoma State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, Using substantially equivalent data provided by the hospital:

(i) treatment of a neurological injury;

(ii) treatment of cancer;

(iii) treatment of cardiovascular disease;

(iv) obstetrical or childbirth services; or

(vi) surgical care except that this exemption will not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery.

(D) a hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital, according to the most recent list of LTCH's published on the CMS http://www.cms.gov/LongTerm CareHospitalPPS/08download.asp or as a children's hospital; and

(E) a hospital that is certified by CMS as a critical access hospital, according to the most recent list published by Flex Monitoring Team for Critical Access Hospital (CAH) Information at http:www.flexmonitoring.org/cahlistRA.cgi, which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) **The Supplemental Hospital Offset Payment Program Assessment.**

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. The assessment rate until December 31, 2012, is two and one-half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%).

(2) OHCA will review and determine the amount of annual assessment in December of each year.
(3) A hospital may not charge any patient for any portion of the SHOPP assessment.
(4) The Method of collection is as follows:
(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.
(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the assessment rate, the hospital's net patient revenue calculation, and the assessment amount.
(C) New hospitals will only be added at the beginning of each calendar year.
(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)
(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 5% of the amount and interest of 1.25% per month. The SHOPP assessment must be received by OHCA no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the assessment is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).
(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA will add to the assessment:
(i) a penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and
(ii) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.
(iii) the quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. In accordance with OAC 317:2-1-15 SHOPP appeals.
(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.
(e) **Supplemental Hospital Offset Payment Program Cost Reports.**
(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.
(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.
(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section

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

(4) Net hospital patient revenue is determined using the data from each hospital's fiscal year 2009 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file.

(5) If a hospital's fiscal year 2009 Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file dated December 31,2010, the hospital will submit a copy of the hospital's 2009 Medicare Cost Report to the Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a 2009 Medicare Cost Report, the hospital will submit its initial Medicare Cost Report to Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis. Hospitals whose assessments were based on partial year cost reports will be reassessed the following year using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) **Closure, merger and new hospitals.**

(1) If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and denominator of which is 365. Within 30 days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by November 1,2011 for the 2012 assessment, and for subsequent years' assessment calculation by September 30 of the preceding year.

(g) **Disbursement of payment to hospitals.**

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of the inpatient supplemental payment pool as reduced by payments distributed in paragraph (1) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital; not to exceed the UPL for the class.

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital; not to exceed the UPL for the class.

(3) If any retrospective audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed. If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

Presentation to the Committee on Rates and Standards
Proposed Revision to Payment Rate for
Children's Long Term Care Sub-Acute Hospitals
August, 2010

Background

Since May 01, 2000 reimbursement for all Children's Sub-Acute Long Term Care Hospitals been made through a prospective rate. The rate was initially set at 85.7% of the existing statewide median rehab level of care per diem rate. Currently, the Children's Center located in Bethany, Oklahoma, is the only facility of this type contracting with the OHCA. For the period beginning 05-01-09 the rate was set at the estimated allowable cost of $537.40 per day and as part of the budget crises and the OHCA efforts to comply with our constitutional responsibility under Article10, Section 23 of the Oklahoma Constitution the rate was adjusted to $519.93 per day on April 1, 2010.

Proposed Change

For the period beginning 11-01-11 OHCA staff proposes that the rate for this facility type be adjusted by $2.61 PPD to $522.54 PPD to adjust for the Children's Center switching from transporting the children to OU Med Center for Botox injections and performing all of the procedures in-house. These costs were paid outside of the rate directly to OU in separate invoices for the service and for the Botox. OHCA passed rules that require both the service and the Botox to be on the same 1500 claim, i.e. insuring that the treatment was made by qualified practitioners. The Children's center has physicians qualified to render the treatments and wishes to do them on an inpatient basis. The only cost not currently in their rate calculation is for the cost of the meds; the $2.61 per day. The main reason for this change is to lessen the trauma to these fragile patients by not having to transport them to other locations for the treatment.

Budget Impact

There would be an estimated savings of $1,642 to the annual budget for OHCA.
The savings come from the administration costs assumed by the Children's Center.

PRESENTATION TO THE STATE PLAN AMENDMENT
REIMBURSEMENT COMMITTEE
PUBLIC HEALTH CLINIC SERVICES
AUGUST 30, 2011

ISSUE

County Health Departments (CHDs) have been enrolled as SoonerCare providers of clinical services and billing "like physicians" using CPT codes, since the implementation of the national code sets mandated by the HIPAA code conversion. Public Health Nurses (PHNs) employed by CHDs provide screening and preventive health services within their scope of practice in accordance with state law. PHNS include RNs, LPNs and Nurse Practitioners (NPs). Generally, PHN primary and preventive services are provided under "approved orders" without the presence of a physician on site. However, PHNs that are not NPs meet only the provider qualifications for a limited number of nurse CPT codes with the physician in the office suite. Further, CPT codes under the SoonerCare Physician Fee Schedule (PFS) do not allow the OSDH to receive full cost reimbursement. Prior to HIPAA, local codes were used by PHNs to bill for compensable services.

OSDH PROPOSED REIMBURSEMENT

Public Health Clinic Fee Schedule
OSDH requests that OHCA implement a separate fee schedule for Clinic services that would allow CHDs to receive full cost reimbursement. Since a standardized cost report has not been developed or approved by CMS for this provider type, the rates have been established from existing fees or Medicare rates. (Refer to Attachment A - Fee Schedule for proposed rates). NPs would continue to be paid using the SoonerCare Physician fee schedule.

For reasonableness, we compared the proposed "visit" rate of **$49.27** for primary and preventive nursing encounters, to the encounter rate for a similar provider type. For example, the CHD delivery model is similar to the Rural Health Clinic (RHC) model, in that in Oklahoma, a nurse practitioner (NP) can provide primary care, and in that CHDs provide services in rural and medically underserved areas to individuals who have limited access to care. (Refer to Attachment B for a description of RHC services). The CY2011Medicare upper payment limit (UPL) rate per visit for independent RHCs is *$78.07*. Since primarily RNs rather than physicians or other mid-level practitioners provide services in a CHD, and the proposed rate is *63 percent* of the RHC rate.

Under CMS guidelines (Federal Register Notice CMS-2213-P, issued September 28, 2007) a State may pay more than Medicare for some services or facilities, and less than Medicare for others, as long as the aggregate Medicaid payment is equal to or less than the amount that Medicare would pay in the aggregate, which is the upper payment limit (UPL). We believe the proposed visit rate is reasonable and within (or below) the UPL for clinic providers.

BACKGROUND

➢ Billing Issues

- PHNs provide immunizations under approved orders in accordance with the Advisory Committee on Immunization Practice (ACIP) guidelines for adults. Current OHCA rules for PHYSICIAN services indicate that the cost for vaccine administration (e.g., CPT 90465) is included in the cost of the vaccine and is therefore not separately payable[1]. OSDH believes that a separate administration fee is covered as a preventive service under OHCA rules for Public Health Clinics at OAC 317:30-5-1155, that specify that immunizations are administered in accordance with ACIP guidelines[2]. CHDs have been

[1] However, the pricing methodology for the vaccine product (% of AWP) does not include the cost of administration.

[2] In addition, Section 4106 of the Affordable Care Act amended Section 1905 (a)(13) of the Social Security Act to add clarification for covered preventive services: "with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the

enrolled as Public Health Clinics since October 2010. OHCA has concerns with payment for the vaccine administrative fee to CHDs as a preventive service based on the exclusion in PHYSICIAN rules.

- Recently OHCA auditors have discovered improper coding for services rendered by PHNs (RNs and LPNs) under approved orders. OSDH has revised its billing instructions to CHDs to specify that only the nurse code (CPT 99211) is appropriate, and only if the client is "established". These guidelines are not compatible with the CHD business model and for the population served by CHDs. For example, some clinic visits do not require the professional level of a physician or Nurse Practitioner (NP) (e.g. services to determine eligibility for pregnancy related services provided to a new patient, in accordance with OAC 317:35-6-38). Therefore all of these and other standing order screening and preventive services for "new" patients would not be reimbursable.

➢ **Medicaid Benefits and Financing**

Medicaid benefits can be provided under different benefit categories, and are often shaped by the financing arrangements by which they are delivered. According to Section 4385 of the State Medicaid Manual, preventive services may be covered in a variety of contexts. In addition to including preventive services as an integral component of PHYSICIAN services, the preventive aspects of CLINIC services and EPSDT services are specifically included in Medicaid regulations. The OHCA and the OSDH have executed an interagency agreement (IAA) to make maximum use of public health and Title V services, with OSDH providing state matching funds for covered services.

Under current Medicaid law, governmentally operated health care providers may receive the full cost of furnishing Medicaid services, which could mean rates that substantially exceed those available to other classes of providers. In 2005, a state plan amendment was approved for reimbursement to CHDs under the Medicaid "Clinic" benefit (Section 1905(a)(9) of the Social Security Act). This separate classification would allow CHDs the opportunity to receive full cost reimbursement for serving SoonerCare members.

DESCRIPTION OF PUBLIC HEALTH NURSING VISIT (T1001)

Eligible Practitioners

- Licensed Public Health Nurses (PHNs) employed by a County Health Department

Billable Visits

A PHN visit would include the following services provided within the PHN scope of practice and state law, as authorized by OAC rules at 317:30-5-1158:

- health promotion and counseling education;
- medication management;
- nursing assessment, execution of medical regime including administration of medications and treatment;
- home visits;
- nursing treatments;
- administration of injectable medications;
- family planning follow-up encounter visits (OAC 317:30-5-466(1)(C).

Director of the Centers for Disease Control and Prevention) *and their administration*" (emphasis added).

PRESENTATION TO THE STATE PLAN AMENDMENT
REIMBURSEMENT COMMITTEE
PUBLIC HEALTH CLINIC SERVICES
AUGUST 30, 2011

Non-Covered Services

- Services that are part of the WIC (Women, Infants and Children Food Program) clinic package such as height, weight, B/P and client history.

BUDGET IMPACT AND PROPOSED EFFECTIVE DATE

Through the IAA, OSDH pays the state match for services provided by CHDs. There is no budget impact to OHCA. The effective date is November 1, 2011.

ATTACHMENT A
Public Health Clinic Fee Schedule

HCPC	Mod	Procedure Code Description	Unit	Billing Limitations	Rate	Source
T1001	*	Nursing Assessment/Evaluation	Visit	One per day Administration of Injections included in rate. Labs and drugs billed separately. Cannot bill on same day as preventive exam e.g. (EPSDT; FP)	**$49.27**	Level 1 APC Clinic Rate - 2011
S9446	HQ	Patient Education, NOC group	Session	Does not include nutritional counseling by nutritionist	**$24.63**	50% of the PHN visit rate
SERVICES FOR PERSONS INFECTED WITH TB						
T1023		Screening to Determine the Appropriateness of an individual for participation in a specified program	Visit	Visit after positive test. Investigations not covered. Lab and X-Ray, Drugs billed separately	**$97.74**	100% of 2011 Medicare - 99203
H0033		Oral Medication Administration (DOT)	Visit	Cannot be billed on same day as T1016	**$9.32**	50% of 2011 Medicare 99211

* Excludes C1

Attachment B – PUBLIC HEALTH CLINIC REIMBURSEMENT
DESCRIPTION OF RURAL HEALTH CLINIC SERVICES

42 C.F.R. § 440.20 Outpatient hospital services and rural health clinic services

Title 42 - Public Health

(b) *Rural health clinic services.* If nurse practitioners or physician assistants (as defined in §481.1 of this chapter) are not prohibited by State law from furnishing primary health care, "rural health clinic services" means the following services when furnished by a rural health clinic that has been certified in accordance with part 491 of this chapter.

(1) Services furnished by a physician within the scope of practice of his profession under State law, if the physician performs the services in the clinic or the services are furnished away from the clinic and the physician has an agreement with the clinic providing that he will be paid by it for such services.

(2) Services furnished by a physician assistant, nurse practitioner, nurse midwife or other specialized nurse practitioner (as defined in §§405.2401 and 491.2 of this chapter) if the services are furnished in accordance with the requirements specified in §405.2414(a) of this chapter.

(3) Services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. (See §§405.2413 and 405.2415 of this chapter for the criteria for determining whether services and supplies are included under this paragraph.)

(4) Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:

(i) The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see §405.2417 of this chapter):

(ii) The services are furnished by a registered nurse or licensed practical nurse or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic;

(iii) The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

(iv) The services are furnished to a homebound recipient. For purposes of visiting nurse care, a "homebound" recipient means one who is permanently or temporarily confined to his place of residence because of a medical or health condition. He may be considered homebound if he leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or a skilled nursing facility.

****

42 C.F.R. § 447.371 Services furnished by rural health clinics

The Medicare and Medicaid programs provide payment on a cost-related basis for outpatient physician and certain non-physician services. A visit means a face-to-face encounter between a clinic patient and any health professional whose services are reimbursed under the state plan.

Cost Calculation – RNs and LPNs

1	**$20.37**	Mean Hourly Wage - All RN classes (Excluding APN)
2	**$13.92**	Mean Hourly Wage - All LPN classes
3	0.93	Pct. RN
4	0.07	Pct LPN
5	**$19.92**	Blended Hourly Wage
6	1.54	Fringe Benefits Factor
7	**$30.68**	Total Salary & Benefits
8	1.226	Indirect Costs Factor, Off-site [1]
9	**$37.61**	Sub- Total Labor Cost Per visit
10	$3.00	Est for Basic Supplies
11	**$40.61**	**Total Costs per FTE hour**
12	2080	FTE Hours per Year
13	5	Weeks Unavailable (Training, Non-clinical time, leave)
14	1880	Available Hours per Year (2080 - weeks unavailable * 40)
15	$40.61	Cost Per FTE Hour (Line 11)
16	$84,477.59	Annual Cost per FTE
17	1880	Available Hours
18	**$44.93**	Rate per Available Hour (Encounter)

Source:

1 OSDH - F & A Cost Rate agreement, FY 2010

Cost Calculation - Advanced Practice Nurses

1	**$28.34**	Mean Hourly Wage - Advanced Practice Nurse
2	1.54	Fringe Benefits Factor
3	**$43.64**	Total Salary & Benefits
4	1.226	Indirect Costs Factor, Off-site [1]
5	**$53.51**	Sub- Total Labor Cost Per visit
6	$3.00	Est for Basic Supplies
7	**$56.51**	**Total Costs per FTE hour**
8	2080	FTE Hours per Year
9	5	Weeks Unavailable (Training, Non-clinical time, leave)
10	1880	Available Hours per Year (2080 - weeks unavailable * 40)
11	**$56.51**	Cost Per FTE Hour (Line 11)
12	$117,534.67	Annual Cost per FTE
13	1880	Available Hours
14	**$62.52**	Cost Rate per Available Hour (Encounter)
15	**45.28**	Average Payment Per Claim (SFY11 Claims Payment data)
16	$(17.24)	Gain (Loss) per APN Encounter

Source:

1 OSDH - F & A Cost Rate agreement, FY2010

2 OHCA claims payment data, SFY2010

Oklahoma Health Care Authority
Finance Division
Presentation to the State Plan Reimbursement Committee
Supplemental Outpatient Hospital Payment to Level I Trauma Centers
August 30, 2011

Background

Under CMS regulations, States are allowed to pay hospitals up to the amount Medicare would pay under comparable circumstances. This is known as the upper payment limit (UPL). House Bill 1381, signed by the Governor on May 13, 2011, creates a Supplemental Hospital Offset Payment Program (SHOPP) which funds supplemental payments to hospitals up to their UPL. However some hospitals are excluded from the program.

This proposal seeks to pay all in-state hospitals that have Level I Trauma Centers that are excluded from the SHOPP Act a supplemental outpatient hospital payment using the Medicare cost methodology. Hospitals that have Level I Trauma Centers are currently eligible for a supplemental ***inpatient*** payment using the Medicare PPS methodology.

Proposed Rate Methodology for the Supplemental Outpatient Payment for Hospitals with Level I Trauma Centers

Allowable outpatient charges for eligible hospitals will be converted to costs using the hospital's cost to charge ratio (CCR). This is defined as the hospital's UPL. Allowable costs are then compared to corresponding Medicaid payments for the services. The difference is known as the UPL gap. Payments will be made up to the UPL to the extent that those facilities have and transfer to the OHCA the state share of the payments. The state share will meet all requirements from federal guidelines as allowable intergovernmental transfers.

2011 Upper Payment Limit Gap

Based on state fiscal year 2011 data, there is currently only one (1) Oklahoma hospital that has a Level I Trauma Center that would be eligible for a supplemental outpatient hospital payment. The allowable outpatient cost (UPL) for this facility is $37,296,843 (37.3 million dollars) while the corresponding payments are $22,840,217 (22.8 million dollars).The OHCA has determined that subtracting the total Medicaid payments from the UPL leaves a "gap" of $14,456,626 (14.4 million dollars). This dollar value sets the amount OHCA could pay for SFY2011. OHCA will use this amount as an estimate for SFY2012 and will reconcile to assure the UPL is not exceeded at the end of SFY2012. If any payments exceed the UPL, they will be recouped.

Budget Impact

The estimated cost to the Medicaid program will be 14.4 million dollars; since 5.2 million in state funds will be transferred from the qualifying hospitals there is no budget impact to OHCA.

Effective Date
November 1, 2011

Oklahoma Health Care Authority
Financial Services Division
Presentation to the Committee on Rates & Standards
Proposed Reimbursement Method for Nursing Facilities Serving Adults

Background

As found in O.S. 56-1011.5 the Legislature directed the Authority to develop a graduated or tiered reimbursement methodology for calculating state Medicaid program reimbursement in addition to the direct care, base rate and other components established under previous legislation. Under this direction the Authority solicited bids from qualified vendors to establish a system to support an incentive reimbursement methodology for Oklahoma Nursing Facilities. This program is titled "Focus on Excellence", (FOE), and the contracted vendor was *My Inner View*. The contract with My Inner View has lapsed and management has determined that it would be an opportune time to create a more logically organized performance metric set for the FOE program. The goals are to simplify the reporting process as much as possible gain more precision and fairness in ratings and payment allocations, expand information to consumers, add focus on culture of care and staff competency and lower OHCA administrative costs by rebalancing of insourcing and outsourcing of program operations. The Opportunities for Living Life (OLL) division organized an advisory board of providers and advocacy groups and contracted with ARC Consulting to review all data in use and the processes of collection in order to make recommendations for changes and additions to help meet our goals. The resulting recommendations will be implemented as per the proposal below.

Current Methodology

The Authority currently pays an incentive payment of one to five percent to participating facilities participating in the Focus on Excellence program. For each two metrics that the facility meets the threshold, an additional percent is paid as a component of the rate.

The current metrics for payment are:

(1) Quality of Life
(2) Resident/Family Satisfaction
(3) Employee Satisfaction
(4) CNA/Nurse Assistant Turnover & Retention
(5) Nurse Turnover & Retention
(6) System-wide Culture Change
(7) Clinical Measures
(8) SoonerCare Occupancy and Medicare Utilization
(9) Nurse Staffing per patient day
(10) State Survey Compliance

Proposed Methodology

Staff, upon recommendations of the advisory board and ARC, proposes to establish the following metrics and thresholds for the FOE program.

1. **Person Centered Care**: *Point Value of 120*
   Facility must meet 6 out of 10 of the established measurement artifacts of culture change to receive the points for this metric.

Oklahoma Health Care Authority
Financial Services Division
Presentation to the Committee on Rates & Standards
Proposed Reimbursement Method for Nursing Facilities Serving Adults

2. **Direct Care Staffing:** *Point Value of 50*
   Facility must maintain a direct care staffing ratio of 3.5 hours per patient day to receive the points for this metric.
3. **Resident/Family Satisfaction:** *Point Value of 80*
   Facility must maintain a weighted score of 72.0 in order to receive the points for this metric.
4. **Employee Satisfaction:** *Point Value of 50*
   Facility must maintain a weighted score of 65 or better in order to receive the points for this metric.
5. **Licensed Nurse Retention:** *Point Value of 50*
   Facility must maintain a 1 year tenure rate for 60% or better of its Licensed Nursing Staff in order to receive the points for this metric.
6. **CNA Retention:** *Point Value of 50*
   Facility must maintain a 1 year tenure rate for 50% or better of is CNA Staff to receive the points for this metric.
7. **Distance Learning Program Participation:** *Point Value of 35*
   Facility must sign up and use approved distance learning programs for its direct care staff in order to receive the points for this metric. A percentage of participation will be established later when adequate data to establish thresholds has been collected.
8. **Peer Mentoring Program Participation:** *Point Value of 30*
   Facility must sign up and use approved peer mentoring programs in order to receive the points for this metric. A percentage of participation will be established later when adequate data to establish thresholds has been collected
9. **Leadership Commitment:** *Point Value of 35*
   Facility must meet 6 out of 10 of the established measurement artifacts in order to receive the points for this metric.

In addition to the Metrics and thresholds above:

- A facility will be able to earn from 1 to 500 points for meeting the established metrics and payment will be established at $.01 per point.
- A facility must earn a minimum of 100 points to receive any payment.
- A facility will forfeit all eligibility for payment in the FOE program for any measurement quarter that the facility receives a citation from the Health Department with a Severity Level of I or higher and the loss of eligibility will continue for any measurement quarters that CMS bans new admissions for the facility.

Effective Date of Change

The above changes will become effective with payment dates of April 1, 2012 based on data collections for the Quarter ending December 31, 2011.

Oklahoma Health Care Authority
Financial Services Division
Presentation to the Committee on Rates & Standards
Proposed Reimbursement Method for Nursing Facilities Serving Adults

Rates of payment based on the current methodology will be made for the fourth quarter ending December 31, 2011 and will be maintained for the quarter ending on March 31, 2012 while transition to the new methodology is accomplished.

Budget Impact

The OLL Division believes that there will be savings to the administrative costs of the program but an accurate projection is not available because bids for outside survey work have not been finalized. The OHCA will house the data and the public website for this program.

The payments under the new methodology to the facilities are projected to be at or near the same levels that are currently being paid. OHCA staff will be monitoring the points and payments and will adjust to the available funds for any material differences.

Recommendation 1: Prior Authorize Type 2 Diabetes Medications

The Drug Utilization Review (DUR) Board recommends prior authorization of Type 2 Diabetes Medications with the following criteria:

1. To qualify for a Tier 2 medication, the member must have a trial of a Tier 1 medication (must include a trial of metformin titrated up to maximum dose), or a clinical reason why a Tier 1 medication is not appropriate.
2. For initiation with dual or triple therapy, additional Tier 2 medications can be approved based on current AACE or ADA guidelines.
3. To qualify for a Tier 3 medication, the member must have tried a Tier 2 medication in the same category and have a documented clinical reason why the Tier 2 medication is not appropriate.
4. To qualify for a Special Prior Authorized medication, the member must be currently stabilized on the requested product or have attempted at least 3 other categories of Tier 2 or Tier 3 medications, or have a documented clinical reason why the requested product is necessary for the member.
    a. For members with steatohepatitis, pioglitazone can be approved after a trial of a Tier 1 medication (must include a trial of metformin titrated up to maximum dose), or a clinical reason why a Tier 1 medication is not appropriate.

Tier 1	Tier 2†	Tier 3	Special PA
Biaguanides	Supplementally rebated or	**DPP-4 Inhibitors**	**Biaguanides**
Metformin	best net price product from	Saxagliptin	Riomet Soln*
Metformin SR	each class in Tier 3.	Saxagliptin-Metformin	Metformin Long-Acting‡
Metformin-Glyburide		Sitagliptin	
Metformin-Glipizide		Sitagliptin-Metformin	**Thiazolidinediones**
		Linagliptin	Rosiglitazone
Sulfonylureas			Pioglitazone
Glyburide		**Glinides**	Rosiglitazone-Metformin
Glyburide Micronized		Repaglinide-Metformin	Rosiglitazone-Glimepiride
Glipizide		Repaglinide	Pioglitazone-Metformin
Glipizide SR		Nateglinide	Pioglitazone-Glimepiride
Glimepiride			
		GLP-1 Agonists	**Amylinomimetic**
Miscellaneous		Exenatide	Pramlintide‡
Chlorpropamide		Liraglutide	

Tolbutamide		**<u>Alpha-Glucosidase Inhibitors</u>** Acarbose Miglitol	

*No prior authorization required for member 12 and under.
†At least one Tier 2 from each Tier 3 category will be determined based on supplemental rebate or best federal rebate.
ǂSpecial criteria currently apply.

Recommendation 2: Prior Authorize Zuplenz™

The DUR Board recommends prior authorization of Zuplenz™ (ondansetron) with the following criteria:

1. FDA-approved indication.
2. Must provide a clinically significant reason why the member cannot take all other available formulations of generic ondansetron.

Recommendation 3: Prior Authorize Xiaflex®

The DUR Board recommends medical prior authorization of Xiaflex® with the following approval criteria:

1. FDA approved indication of Dupuytren's contracture with palpable cord, functional impairment and fixed-flexion contractures of the metacarpophalangeal (MP) joint or proximal interphalangeal (PIP) joint of 30 degrees or more.
2. Must be 18 years or older.
3. Not a candidate for needle aponeurotomy.
4. Physician must be trained in treatment of Dupuytren's contracture and injections of the hand.
5. Quantity limit of 3 doses (one dose per 4 weeks) per cord.

Recommendation 3: Prior Authorize Berinet®, Cinryze®, and Kalbitor®

The DUR Board recommends medical prior authorization of Berinet®, Cinryze®, and Kalbitor® with the following approval criteria:

Criteria for Approval for Cinryze® (C1 esterase inhibitor)

1. Documented diagnosis of Hereditary Angioedema
2. For prophylaxis of Hereditary Angioedema
3. History of at least one or more abdominal or respiratory HAE attacks per month, or history of laryngeal attacks, or three or more emergency medical treatments per year
4. Documented intolerance, insufficient response, or contraindication to
    a. attenuated androgens (e.g. danazol, stanozolol, oxandrolone, methyltestosterone) AND
    b. antifibrinolytic agents (e.g. ε – aminocaproic acid, tranexamic acid) OR
    c. recent hospitalization for severe episode of angioedema
5. Not currently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy.

6. Dosing:
    a. The recommended dose of Cinryze® is 1000 units IV every 3 to 4 days, approximately 2 times per week, to be infused at a rate of 1 ml/min.
    b. Initial doses to be administered in outpatient setting by healthcare provider. Patients can be taught by their healthcare provider to self-administer Cinryze® intravenously.
    c. Quantity limit of 8000 units per month will apply, i.e. 2 treatment per week, or 8 treatments per month.

Criteria for Approval of Berinert® (C1 esterase inhibitor):

1. Documented diagnosis of Hereditary Angioedema
2. For acute attacks of Hereditary Angioedema

Criteria for Approval of Kalbitor® (ecallentide):

1. Documented diagnosis of Hereditary Angioedema
2. For acute attacks of Hereditary Angioedema

Submitted to the C.E.O. and Board on October 13, 2011

AUTHORITY FOR EXPENDITURE OF FUNDS
SoonerCare Call Center Services

BACKGROUND

The Oklahoma Health Care Authority issued a Request for Proposal (RFP) for the provision of the SoonerCare Call Center. This contract will replace the existing services being provided by Life Care Health Services and Hewlett-Packard under contracts that will expire December 31, 2011.

SCOPE OF WORK

- Answer first tier telephone calls from members, providers, and the general community about SoonerCare and other OHCA programs
- Transfer appropriate calls to OHCA second tier call centers
- Answer second tier online enrollment calls and process documentation
- Assist members with primary care provider and dentist information
- Make outbound calls to confirm primary care provider after-hours access and other outbound calls as requested by OHCA
- Provide extended evening and weekend hours

CONTRACT PERIOD

January 1, 2011 through June 30, 2018

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Not-to-exceed $27 million in total; not-to-exceed $2.2 million for SFY12
- The contract has been procured by OHCA through competitive bidding
- Federal matching percentage is 50% (possible 75% match with CMS-approved Advance Planning Document)

RECOMMENDATION

- Board approval to expend funds for SoonerCare Call Center services