OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
December 11, 2014 at 1:00 P.M.
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the November 13, 2014 OHCA Board Meeting Minutes

Item to be presented by Nico Gomez, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) Financial Update – Carrie Evans, Chief Financial Officer

   b) Medicaid Director's Update – Marlene Asmussen, Population Care Management Director

      1) Population Care Management Update

   c) Oklahoma Hospital Association (OHA) Presentation on Transforming Health Care – Craig Jones, OHA President

Item to be presented by Nicole Nantois, Chief of Legal Services

4. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

Item to be presented by Cindy Roberts, Deputy CEO – Planning, Policy & Integrity Division

5. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Emergency Rules:

   The following emergency rules HAVE NOT previously been approved by the Board.

   DHS Initiated Rules:

   A. Amending agency rules at OAC 317:40-1-1 to implement policy changes recommended during the Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) annual policy review process. Home and Community-Based Services (HCBS) Waiver's rules for persons with intellectual disabilities or certain persons with related conditions are amended to: (1) include timeframes for how long psychological evaluations are considered valid to determine eligibility for DDS HCBS Waiver services; (2) include timeframes for reporting any address changes or other contact information to DHS; and (3) provide timeframes when an individual is

removed from the Request for Waiver Services List when the individual fails to respond or does not provide DHS requested information.
Budget Impact: Budget Neutral

(Reference WF # 14-34)

B. Amending agency rules at OAC 317:40-5-3, 317:40-5-5, 317:40-5-6, 317:40-5-11, 317:40-5-13, 317:40-5-40 and revoking agency rules at OAC 317:40-5-4, 317:40-5-9, 317:40-5-10 to comply with 29 CFR 552.109 regarding domestic service employees employed by third-party employers, or employers other than the individual receiving services, or his or her family, or household. The regulation precludes third party employers from claiming the companion exemption.
Budget Impact: Budget Neutral

(Reference WF # 14-23)

Item to be presented by Nancy Nesser, Pharmacy Director

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

   a) Consideration and vote to add Sivextro™ (Tedizolid), Dalvance™ (Dalbavancin), and Orbactiv™ (Oritavancin) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Chairman McFall

7. Action Item – Consideration and Vote upon the Oklahoma Health Care Authority Board Meeting Dates, Times and Locations for Calendar Year 2015

8. New Business

9. ADJOURNMENT

NEXT BOARD MEETING
January 8, 2015
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
November 13, 2014
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on November 12, 2014, 11:00 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on November 7, 2014, 10:00 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:01 p.m.

BOARD MEMBERS PRESENT: Chairman McFall, Vice-Chairman Armstrong, Member Bryant, Member McVay, Member Nuttle, Member Robison, Member Case

OTHERS PRESENT:

Robert Dorrell, BCBS OK
Leon Bragg, OHCA
Becky Moore, OAHCP
Will Widman, HP
Jim Fowler, AstraZeneca
Tewanna Edwards, OHCA
LeKenya Antwine, OHCA
Patrick Harvey, Walgreens
David Dude, American Cancer Society

OTHERS PRESENT:

Terry Cothran, COP
Melissa Hughes, RedRoad Counseling
Brenda Ted, Chickasaw Nation
Dr. Mehta, OHCA
Rick Snyder, OHA
Charles Brodt, HP
Ben Luschen, e-Capitol
Mary Brinkley, LeadingAge OK
Thessali Teague, JRLR

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD OTOBER 9, 2014.

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 McVay moved for approval of the October 9, 2014 board meeting minutes as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Nuttle, Member Bryant

ABSTAINED: Member Case

ITEM 3 / INTRODUCTION OF NEW BOARD MEMBER, TANYA CASE
Chairman McFall

Chairman McFall recognized the newest member of the OHCA Board, Tanya Case by giving a brief background of Ms. Case and the board and Mr. Gomez welcomed her.

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT
Nico Gomez, Chief Executive Officer

4a. FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of September and noted that we have completed our first quarter with $7.1 million state dollars under budget and the agency is under budget in program spending by 1 percent and under budget in administration by 5.8 percent. She stated that the agency is running over budget in drug rebates,

taxes and fees. Looking ahead for October, Ms. Evans predicts the agency will continue to run under budget. For more detailed information, see Item 4a in the board packet.

4b. MEDICAID DIRECOR'S UPDATE
Garth Splinter, State Medicaid Director

Dr. Splinter provided an update for September that included a report on the number of enrollees in the Medicaid program. He also reported on the Insure Oklahoma enrollment, dual enrollees, total providers and select provider type counts.

Member Tanya Case asked what the capacity was for Insure Oklahoma (IO) and Dr. Splinter replied that the only piece that is formally capped is college students at 3,000. Mr. Gomez noted that we have room for growth in the program and that we are continuing to market IO.

For more detailed information, see Item 4b in the board packet.

4c. PROPOSED OHCA 2015 BOARD MEETING DATES AND LOCATIONS
Nico Gomez, Chief Executive Officer

Mr. Gomez presented the proposed board dates for 2015 and mentioned that we will bring the dates back for voting at December's board meeting. He noted that if any of the board members would like to host a board meeting in their hometown, to please let us know. For more detailed information, see Item 4c in the board packet.

ITEM 5 / FOCUS ON EXCELLENCE UPDATE
Jennifer Wynn, Program Coordinator, Provider Rates & Analysis

Ms. Wynn presented a brief history of the Focus On Excellence (FOE) Program. She then discussed the 2013 program transition, in-house advantage, quality improvement and provided a cost analysis. Ms. Wynn noted that we have been invited to speak on a panel at the first National Medicaid Pay for Performance Value Based Purchasing Conference in 2015, and that we are very excited to participate.

Mr. Gomez also recognized Mike Fogarty, Carrie Evans and Lisa Moses for their work in the FOE program. For more detailed information, see Item 5 in the board packet.

ITEM 6 / ANNUAL TRIBAL CONSULTATION UPDATE
Dana Miller, Tribal Relations Director

Ms. Miller provided an update of the 8th Annual Tribal Consultation held October 21, 2014. She noted there were over 60 stakeholders that were in attendance with representation from 18 tribal partner entities. There were numerous topics highlighted that included diabetes and obesity prevention programs, telemedicine in rural areas among other topics. Ms. Miller stated that the Tribal Partnership Planning Session will take place in January 2015 to develop an action plan in addressing the topics discussed during the annual meeting. For more detailed information, see Item 6 in the board packet.

ITEM 7 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTIONITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 8 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES 5030.3.
Burl Beasley, Clinical Pharmacist

a) Consideration and Vote to Add Grastek® (Timothy Grass Pollen Allergen Extract) and Ragwitek™ (Short Ragweed Pollen Allergen Extract) to the Utilization and Scope Prior Authorization Program Under OAC 317:30-5-77.2(e).

MOTION: Member Robison moved for Item 8 as published. The motion was seconded by Member Bryant.

DRAFT

FOR THE MOTION: Chairman McFall, Vice-Chairmam Armstrong, Member Nuttle, Member McVay, Member Case

ITEM 9 / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE
Cindy Roberts, Deputy CEO – Planning, Policy & Integrity Division

a) Consideration and Vote to Approve a Method Change for selected Durable Medical Equipment, Prosthetics, Orthotics and Supply Manually Priced Items – Priced at Fair Market Value.

MOTION: Vice-Chairman Armstrong moved for approval of Item 9 as published. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman McFall, Member McVay, Member Bryant, Member Robison, Member Case

ITEM 10 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4), (7) AND (9).
Nicole Nantois, Chief of Legal Services

Chairman McFall entertained a motion to go into Executive Session at this time.

MOTION: Member Bryant moved for approval to go into Executive Session. The motion was seconded by Vice-Chairman Armstrong.

FOR THE MOTION: Chairman McFall, Member McVay, Member Nuttle, Member Robison, Member Case

a) Discussion of Pending Litigation, Investigations and Claims:

Association of Direct Care Trainers vs. OHCA
Gragert v. OHCA
Peterson v. OHCA
Franz v. OHCA
Melvin v. OHCA

b) 2014 CEO Evaluation

ITEM 11 / NEW BUSINESS

There was no new business.

ITEM 12 / ADJOURNMENT

MOTION: Vice-Chairman Armstrong moved for adjournment. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman McFall, Member Bryant, Member Robison, Member McVay, Member Case

Meeting adjourned at 2:25 p.m., 11/13/2014

NEXT BOARD MEETING
December 11, 2014
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
OKC, OK

Lindsey Bateman
Board Secretary

DRAFT

Minutes Approved: _______________

Initials:________________

DRAFT

FINANCIAL REPORT

For the Four Months Ended October 31, 2014
Submitted to the CEO & Board

- Revenues for OHCA through October, accounting for receivables, were **$1,495,641,067** or **.7% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,392,932,704 or 1.6% under** budget.
- The state dollar budget variance through October is a **positive $12,041,984.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		8.6
Administration		.9
Revenues:		
Drug Rebate		.1
Taxes and Fees		1.7
Overpayments/Settlements		.7
Total FY 15 Variance	**$**	**12.0**

ATTACHMENTS

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

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2015, For the Four Months Ended October 31, 2014

REVENUES	FY15 Budget YTD	FY15 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 379,982,589	$ 379,982,589	$ -	0.0%
Federal Funds	840,922,905	826,528,976	(14,393,929)	(1.7)%
Tobacco Tax Collections	14,963,873	16,656,066	1,692,193	11.3%
Quality of Care Collections	25,778,393	25,741,965	(36,428)	(0.1)%
Prior Year Carryover	61,029,661	61,029,661	-	0.0%
Federal Deferral - Interest	75,228	75,228	-	0.0%
Drug Rebates	66,660,970	66,837,544	176,574	0.3%
Medical Refunds	15,075,365	16,845,674	1,770,309	11.7%
Supplemental Hospital Offset Payment Program	97,678,939	97,678,939	-	0.0%
Other Revenues	4,218,236	4,264,424	46,189	1.1%
TOTAL REVENUES	**$ 1,506,386,158**	**$ 1,495,641,067**	**$ (10,745,091)**	**(0.7)%**

EXPENDITURES	FY15 Budget YTD	FY15 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 18,898,566**	**$ 17,339,822**	**$ 1,558,744**	**8.2%**
ADMINISTRATION - CONTRACTS	**$ 40,539,067**	**$ 39,487,915**	**$ 1,051,152**	**2.6%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	13,316,543	12,120,559	1,195,984	9.0%
Acute Fee for Service Payments:				
Hospital Services	309,088,511	306,086,938	3,001,573	1.0%
Behavioral Health	7,021,756	6,747,538	274,218	3.9%
Physicians	170,178,528	164,081,642	6,096,886	3.6%
Dentists	47,262,163	46,526,795	735,369	1.6%
Other Practitioners	14,683,397	14,397,039	286,358	2.0%
Home Health Care	7,079,667	6,930,432	149,235	2.1%
Lab & Radiology	27,504,606	27,607,097	(102,490)	(0.4)%
Medical Supplies	13,619,257	13,390,658	228,599	1.7%
Ambulatory/Clinics	42,751,290	43,059,192	(307,902)	(0.7)%
Prescription Drugs	156,961,783	151,953,096	5,008,686	3.2%
OHCA Therapeutic Foster Care	697,841	677,641	20,200	2.9%
Other Payments:				
Nursing Facilities	197,603,243	196,605,028	998,215	0.5%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	20,899,918	20,288,269	611,650	2.9%
Medicare Buy-In	45,172,200	43,746,722	1,425,479	3.2%
Transportation	24,564,052	24,548,876	15,176	0.1%
Money Follows the Person-OHCA	354,010	223,548	130,461	0.0%
Electonic Health Records-Incentive Payments	7,356,320	7,356,320	-	0.0%
Part D Phase-In Contribution	25,093,787	24,773,686	320,101	1.3%
Supplemental Hospital Offset Payment Program	224,983,892	224,983,892	-	0.0%
Total OHCA Medical Programs	**1,356,192,764**	**1,336,104,967**	**20,087,797**	**1.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,415,719,779**	**$ 1,392,932,704**	**$ 22,787,075**	**1.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 90,666,380**	**$ 102,708,363**	**$ 12,041,984**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2015, For the Four Months Ended October 31, 2014

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 12,170,647	$ 12,115,540	$ -	$ 50,088	$ -	$ 5,019	$ -
Inpatient Acute Care	401,913,062	212,291,131	162,229	1,385,631	180,456,312	373,649	7,244,110
Outpatient Acute Care	124,782,494	91,770,895	13,868	1,388,374	30,134,190	1,475,166	
Behavioral Health - Inpatient	22,214,256	4,163,152	-	97,335	13,847,473		4,106,296
Behavioral Health - Psychiatrist	3,130,303	2,584,385	-	-	545,917	-	-
Behavioral Health - Outpatient	9,871,782	-	-	-	-	-	9,871,782
Behavioral Health Facility- Rehab	77,913,707	-	-	-	-	33,123	77,913,707
Behavioral Health - Case Management	6,633,649	-	-	-	-	-	6,633,649
Behavioral Health - PRTF	29,920,141	-	-	-	-	-	29,920,141
Residential Behavioral Management	7,585,073	-	-	-	-	-	7,585,073
Targeted Case Management	21,578,314	-	-	-	-	-	21,578,314
Therapeutic Foster Care	677,641	677,641	-	-	-	-	-
Physicians	184,311,649	161,952,972	19,367	2,055,975	-	2,109,303	18,174,033
Dentists	46,533,628	46,522,074	-	6,834	-	4,720	-
Mid Level Practitioners	1,122,714	1,114,688	-	7,378	-	648	-
Other Practitioners	13,318,318	13,131,652	148,788	36,615	-	1,263	-
Home Health Care	6,934,896	6,922,303	-	4,465	-	8,129	-
Lab & Radiology	28,225,768	27,418,117	-	618,671	-	188,980	-
Medical Supplies	13,478,751	12,451,233	903,845	88,093	-	35,579	-
Clinic Services	42,692,023	39,822,136	-	239,320	-	72,702	2,557,866
Ambulatory Surgery Centers	3,233,090	3,155,273	-	68,736	-	9,081	-
Personal Care Services	4,304,333	-	-	-	-	-	4,304,333
Nursing Facilities	196,605,028	123,808,975	72,794,072	-	-	1,982	-
Transportation	24,427,050	23,521,865	880,078	-	-	25,107	-
GME/IME/DME	37,603,503	-	-	-	-	-	37,603,503
ICF/IID Private	20,288,269	16,627,560	3,660,709	-	-	-	-
ICF/IID Public	28,524,686	-	-	-	-	-	28,524,686
CMS Payments	68,520,408	68,302,743	217,665	-	-	-	
Prescription Drugs	154,911,790	151,322,742	-	2,958,694	-	630,354	-
Miscellaneous Medical Payments	121,827	117,522	-	-	-	4,304	-
Home and Community Based Waiver	63,270,120	-	-	-	-	-	63,270,120
Homeward Bound Waiver	30,715,708	-	-	-	-	-	30,715,708
Money Follows the Person	5,213,751	223,548	-	-	-	-	4,990,203
In-Home Support Waiver	8,708,016	-	-	-	-	-	8,708,016
ADvantage Waiver	56,633,351	-	-	-	-	-	56,633,351
Family Planning/Family Planning Waiver	2,992,585	-	-	-	-	-	2,992,585
Premium Assistance*	13,996,779	-	-	13,996,779	-	-	-
Electronic Health Records Incentive Payments	7,356,320	7,356,320	-	-	-	-	-
Total Medicaid Expenditures	**$ 1,782,435,429**	**$ 1,027,374,470**	**$ 78,800,619**	**$ 23,002,987**	**$ 224,983,892**	**$ 4,979,108**	**$ 423,327,475**

* Includes $13,886,821.97 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2015, For the Four Months Ended October 31, 2014

REVENUE		FY15 Actual YTD
Revenues from Other State Agencies	$	176,379,208
Federal Funds		267,686,771
TOTAL REVENUES	**$**	**444,065,979**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	63,270,120
Money Follows the Person		4,990,203
Homeward Bound Waiver		30,715,708
In-Home Support Waivers		8,708,016
ADvantage Waiver		56,633,351
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		28,524,686
Personal Care		4,304,333
Residential Behavioral Management		5,820,082
Targeted Case Management		17,538,903
Total Department of Human Services		**220,505,403**
State Employees Physician Payment		
Physician Payments		18,174,033
Total State Employees Physician Payment		**18,174,033**
Education Payments		
Graduate Medical Education		211,228
Graduate Medical Education - Physicians Manpower Training Commission		2,172,666
Indirect Medical Education		31,865,924
Direct Medical Education		3,353,685
Total Education Payments		**37,603,503**
Office of Juvenile Affairs		
Targeted Case Management		964,496
Residential Behavioral Management		1,764,991
Total Office of Juvenile Affairs		**2,729,487**
Department of Mental Health		
Case Management		6,633,649
Inpatient Psychiatric Free-standing		4,106,296
Outpatient		9,871,782
Psychiatric Residential Treatment Facility		29,920,141
Rehabilitation Centers		77,913,707
Total Department of Mental Health		**128,445,574**
State Department of Health		
Children's First		583,458
Sooner Start		1,009,981
Early Intervention		1,594,922
Early and Periodic Screening, Diagnosis, and Treatment Clinic		751,692
Family Planning		(29,506)
Family Planning Waiver		3,009,936
Maternity Clinic		15,094
Total Department of Health		**6,935,577**
County Health Departments		
EPSDT Clinic		261,375
Family Planning Waiver		12,154
Total County Health Departments		**273,529**
State Department of Education		**70,149**
Public Schools		**826,386**
Medicare DRG Limit		**2,250,000**
Native American Tribal Agreements		**519,724**
Department of Corrections		**613,325**
JD McCarty		**4,380,785**
Total OSA Medicaid Programs	**$**	**423,327,475**
OSA Non-Medicaid Programs	**$**	**26,994,979**
Accounts Receivable from OSA	**$**	**6,256,476**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

Fiscal Year 2015, For the Four Months Ended October 31, 2014

REVENUES		FY 15 Revenue
SHOPP Assessment Fee	$	97,619,436
Federal Draws		142,145,109
Interest		31,054
Penalties		28,449
State Appropriations		(15,200,000)
TOTAL REVENUES	$	224,624,048

EXPENDITURES	Quarter	Quarter		FY 15 Expenditures
Program Costs:	7/1/14 - 9/30/14	10/1/14 - 12/31/14		
Hospital - Inpatient Care	92,872,986	87,583,326	$	180,456,311
Hospital -Outpatient Care	15,052,817	15,081,373	$	30,134,190
Psychiatric Facilities-Inpatient	6,919,304	6,928,169	$	13,847,473
Rehabilitation Facilities-Inpatient	272,784	273,133	$	545,917
Total OHCA Program Costs	115,117,891	109,866,001	$	224,983,892
Total Expenditures			$	224,983,892
CASH BALANCE			$	(359,844)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2015, For the Four Months Ended October 31, 2014

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 25,728,926	$ 25,728,926
Interest Earned	13,040	13,040
TOTAL REVENUES	**$ 25,741,965**	**$ 25,741,965**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 71,576,107	$ 25,753,083	
Eyeglasses and Dentures	94,085	33,857	
Personal Allowance Increase	1,123,880	404,372	
Coverage for Durable Medical Equipment and Supplies	903,845	325,203	
Coverage of Qualified Medicare Beneficiary	344,252	123,862	
Part D Phase-In	217,665	217,665	
ICF/IID Rate Adjustment	1,778,886	640,043	
Acute Services ICF/IID	1,881,823	677,080	
Non-emergency Transportation - Soonerride	880,078	316,652	
Total Program Costs	**$ 78,800,619**	**$ 28,491,817**	**$ 28,491,817**
Administration			
OHCA Administration Costs	$ 163,623	$ 81,811	
PHBV - Quality of Care Expense	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 163,623**	**$ 81,811**	**$ 81,811**
Total Quality of Care Fee Costs	**$ 78,964,242**	**$ 28,573,629**	
TOTAL STATE SHARE OF COSTS			**$ 28,573,629**

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 2015, For the Four Months Ended October 31, 2014

REVENUES	FY 14 Carryover	FY 15 Revenue	Total Revenue
Prior Year Balance	$ 13,950,701	$ -	$ 7,165,966
State Appropriations	-	-	-
Tobacco Tax Collections	-	13,699,464	13,699,464
Interest Income	-	100,934	100,934
Federal Draws	160,262	9,266,293	9,266,293
All Kids Act	(6,708,502)	36,609	36,609
TOTAL REVENUES	**$ 7,402,461**	**$ 23,103,300**	**$ 30,232,657**

EXPENDITURES		FY 14 Expenditures	FY 15 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 13,785,259	$ 13,785,259
	College Students		109,957	39,563
	All Kids Act		101,563	101,563
Individual Plan				
	SoonerCare Choice		$ 48,339	$ 17,392
	Inpatient Hospital		1,363,024	490,416
	Outpatient Hospital		1,377,574	495,651
	BH - Inpatient Services-DRG		94,767	34,097
	BH -Psychiatrist		-	-
	Physicians		2,054,559	739,230
	Dentists		6,264	2,254
	Mid Level Practitioner		6,908	2,486
	Other Practitioners		35,944	12,933
	Home Health		4,465	1,606
	Lab and Radiology		612,167	220,258
	Medical Supplies		81,635	29,372
	Clinic Services		237,620	85,496
	Ambulatory Surgery Center		63,005	22,669
	Prescription Drugs		2,915,885	1,049,136
	Miscellaneous Medical		-	-
	Premiums Collected		-	(185,314)
Total Individual Plan			**$ 8,902,158**	**$ 3,017,683**
	College Students-Service Costs		**$ 103,864**	**$ 37,370**
	All Kids Act- Service Costs		**$ 186**	**$ 67**
Total OHCA Program Costs			**$ 23,002,987**	**$ 16,981,505**
Administrative Costs				
	Salaries	$ 30,565	$ 412,408	$ 442,973
	Operating Costs	109,709	196,605	306,314
	Health Dept-Postponing	-	-	-
	Contract - HP	96,221	251,545	347,766
Total Administrative Costs		**$ 236,495**	**$ 860,558**	**$ 1,097,053**
Total Expenditures				**$ 18,078,557**
NET CASH BALANCE		**$ 7,165,966**		**$ 12,154,100**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2015, For the Four Months Ended October 31, 2014

REVENUES	FY 15 Revenue	State Share
Tobacco Tax Collections	$ 273,333	$ 273,333
TOTAL REVENUES	**$ 273,333**	**$ 273,333**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,019	$ 1,264	
Inpatient Hospital	373,649	94,122	
Outpatient Hospital	1,475,166	371,594	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,982	499	
Physicians	2,109,303	531,333	
Dentists	4,720	1,189	
Mid-level Practitioner	648	163	
Other Practitioners	1,263	318	
Home Health	8,129	2,048	
Lab & Radiology	188,980	47,604	
Medical Supplies	35,579	8,962	
Clinic Services	72,702	18,314	
Ambulatory Surgery Center	9,081	2,288	
Prescription Drugs	630,354	158,786	
Transportation	25,107	6,324	
Miscellaneous Medical	4,304	1,085	
Total OHCA Program Costs	$ 4,945,985	$ 1,245,894	
OSA DMHSAS Rehab	$ 33,123	$ 8,344	
Total Medicaid Program Costs	$ 4,979,108	$ 1,254,238	
TOTAL STATE SHARE OF COSTS			**$ 1,254,238**

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

October 2014 Data for December 2014 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2014	Enrollment October 2014	Total Expenditures October 2014	Average Dollars Per Member Per Month October 2014
SoonerCare Choice Patient-Centered Medical Home		559,363	**540,592**	**$174,326,336**	
	Lower Cost *(Children/Parents; Other)*		493,386	$125,085,331	$254
	Higher Cost *(Aged, Blind or Disabled; TEFRA; BCC)*		47,206	$49,241,004	$1,043
SoonerCare Traditional		196,936	**236,575**	**$237,520,654**	
	Lower Cost *(Children/Parents; Other)*		125,914	$53,305,042	$423
	Higher Cost *(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		110,661	$184,215,612	$1,665
SoonerPlan*		48,266	**41,943**	**$660,744**	$16
Insure Oklahoma		23,567	**17,209**	**$5,829,263**	
	Employer-Sponsored Insurance	14,795	12,706	$3,519,767	$277
	*Individual Plan**	8,772	4,503	$2,309,495	$513
TOTAL		**828,131**	**836,319**	**$418,336,996**	

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 $132,489,297 are excluded.

Effective July 2014, members with other forms of credible health insurance coverage were no longer eligible for Choice PCMH.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

Net Enrollee Count Change from Previous Month Total	842

New Enrollees	16,219

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare		Monthly Average SFY2014	Enrolled October 2014
Dual Enrollees		**109,653**	**110,919**
	Child	*192*	188
	Adult	*109,461*	110,731

		Monthly Average SFY2014	Enrolled October 2014	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,358**	**15,192**	**$5,375**
	Child	63	56	
	Adult	15,295	15,136	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2014	Enrolled October 2014
Total Providers		**38,330**	**40,754**
	In-State	29,277	30,322
	Out-of-State	9,053	10,432

Provider Network includes providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and specialties.

Program	% of Capacity Used
SoonerCare Choice	43%
SoonerCare Choice I/T/U	20%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2014	*Enrolled October 2014**	Monthly Average SFY2014	Enrolled October 2014
Physician	*8,452*	*9,011*	*13,597*	15,166
Pharmacy	*936*	*889*	*1,266*	1,165
Mental Health Provider	*4,864*	*4,471*	*4,902*	4,521
Dentist	*1,069*	*1,095*	*1,206*	1,251
Hospital	*183*	*191*	*685*	902
Optometrist	*565*	*606*	*594*	641
Extended Care Facility	*356*	*349*	356	349

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

Total Primary Care Providers**	*5,410*	*5,848*	7,011	7,755
Patient-Centered Medical Home	*2,099*	*2,288*	2,188	2,393

**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.

POPULATION CARE MANAGEMENT

Oklahoma HealthCare Authority

POPULATION CARE MANAGEMENT DEPARTMENT

- Case Management Unit
- Health Management Program
- Chronic Care Unit

CASE MANAGEMENT UNIT

Provides case management for members identified through specific programs, episodes or events (obstetrics, pediatrics, other populations)

- Nurses
- Social Service Coordinators

Members are identified through data mining, self-referral, provider referral, community agency/state partner agency referral, legislative referral, intra-agency (OHCA) referral

OBSTETRIC CASE MANAGEMENT INITIATIVES

High-Risk Obstetrical Program – Case management for women approved for HROB benefit set

At-Risk Obstetrical Program – Case management for women determined by screening to be at-risk

Infant Mortality Reduction Program – Case management for pregnant women in 10 counties with highest infant mortality rates

Interconception Care – Extends Infant Mortality Reduction program to provide case management to 13-18 year old women for 1 year post-partum

Strong Start Grant – Case management to women enrolled in Strong Start (group obstetrical visits) program in 4 targeted clinics

PEDIATRIC CASE MANAGEMENT INITIATIVES

Infant Mortality Reduction Program (Baby) – Case management for infants born in 10 counties with highest infant mortality

Private Duty Nursing Case Management – Assessments and case management for children receiving private duty nursing services

Synagis Case Management – Case management for children at risk for RSV receiving Synagis therapy

At-risk Newborn Case Management – Case management for infants screened to be at high-risk

OTHER CASE MANAGEMENT SERVICES

Out of State Care Coordination

Oklahoma Cares – Breast and Cervical Cancer Treatment Program

Complex Case Management / Care Navigation

ER Utilization Case Management

Long-term Care Waiver Assessments

Social Service Coordinators:

- Meals and Lodging requests
- Legislative Inquiries
- Community Resources

HEALTH MANAGEMENT PROGRAM

Members with or at risk for developing chronic conditions are identified through data mining and by the provider

Embedded Health Coaches (RNs) within identified SoonerCare patient-centered medical home practices with a high chronic disease burden

HEALTH MANAGEMENT PROGRAM

Coaches provide care management for identified members (face-to-face in the office and telephonically between visits)

Coaches encourage and enable members to manage their own health to reduce the incidence and severity of chronic disease and improve clinical outcomes

Coaches work closely with the practice staff to close gaps in care utilizing a disease registry as well as assist in care transitions (inpatient and ER)

HEALTH MANAGEMENT PROGRAM

Community Resource Specialists

OHCA Behavioral Health Unit

Practice Facilitation services to assist the practice improve the quality of care provided to chronically ill patients

CHRONIC CARE UNIT

Care Management for members with chronic conditions

Identified through self-referral, provider referral, data mining, transfer from Health Management Program

Targeted hemophilia, sickle cell anemia and hepatitis C cases

Works in tandem with Health Management Program

BEHAVIORAL HEALTH UNIT

Works closely with Population Care Management staff

PCM performs behavioral health screenings and generates referrals within the case documentation system as appropriate

Behavioral Health Unit contacts member and assists them with locating services

BEHAVIORAL HEALTH UNIT

Services for adults include medication management, mental health and substance abuse counseling, and psychiatric care

Services for children include medication management, mental health and substance abuse counseling, testing/counseling, and psychiatric care

BEHAVIORAL HEALTH UNIT

Inpatient Unit is comprised of 12 licensed clinical reviewers

Performs clinical reviews of children (5-21) admitted to inpatient behavioral health facilities and therapeutic foster care agencies

Monitors children through their duration and 7 days after discharge to establish outpatient therapy

Transforming Health Care:

A Proposal for Oklahoma's Future

November 21, 2014

This presentation was developed in conjunction with Manatt Health and informed by discussions with multiple public and private stakeholders.

Elements of the Proposal

- The Case for Change
- Payment and Delivery System Reforms
- Broadening Coverage in Oklahoma

The Case for Change

Forces Driving Reform of Health Care in Oklahoma

- To achieve a balanced budget, Oklahoma must **control state spending.**

  - Oklahoma spends approximately $5 B annually (36% of which is state funds) on the Medicaid program.

- Despite the state's investment in health care, more than 630,000 remain **uninsured (17% of the population**) in Oklahoma; **cost of that care is shifted to the private sector.**

- **Oklahoma has poor health outcomes**, as evidenced by high rates of smoking, obesity, and diabetes.

- The high rates of uninsurance and poor health status contribute to the **high cost of health care in Oklahoma.**

Sources: Bullet 2) Oklahoma Healthcare Authority; 3) Kaiser State Health Facts; 4) United Health Fund's America's Health Rankings® Dec. 2013; The Commonwealth Fund's Scorecard on State Health System Performance for Low-Income Populations, 2013

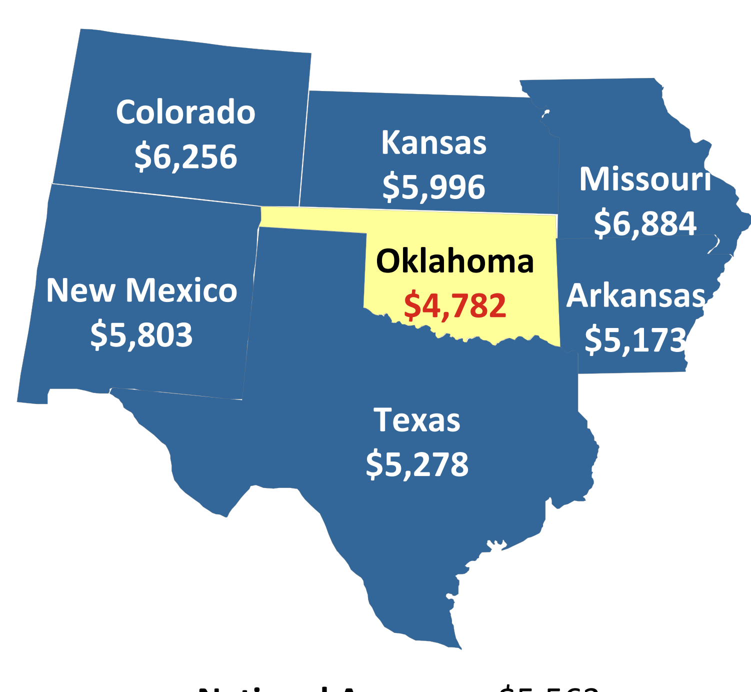
OHA Oklahoma Hospital Association

Oklahoma Must Become a Value-Based Purchaser

- Medicaid spending per beneficiary in Oklahoma is less than the national average and less than spending in neighboring states.

Even so….

- Oklahoma can become a more **prudent purchaser of care**, ensuring access and improving transparency, accountability and value.

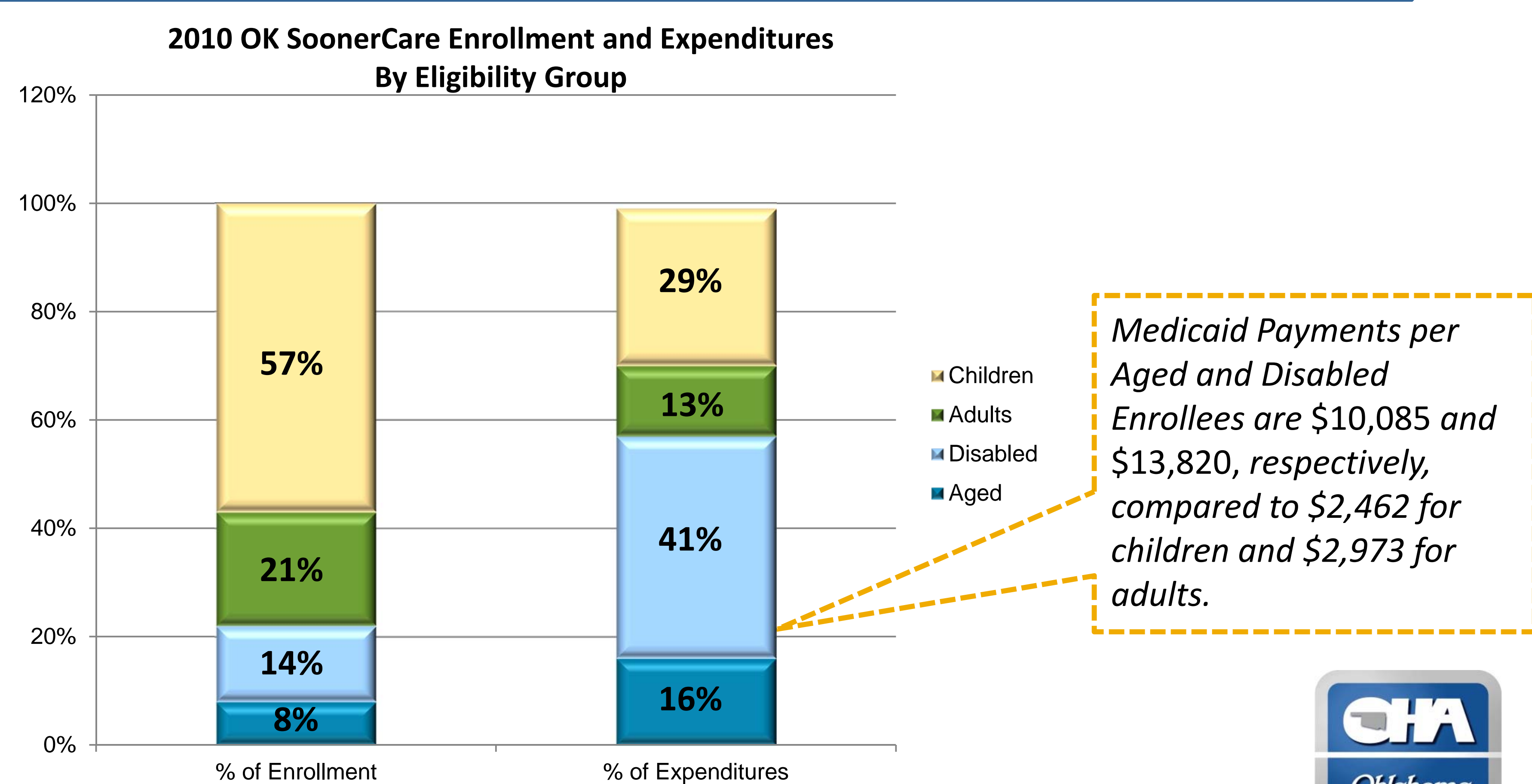


National Average = $5,563

Sources: Kaiser State Health Facts; PHPC, "SoonerCare Choice Program Independent Evaluation," Sept. 2014

A Small Percentage of Beneficiaries Drive Costs

22% of beneficiaries account for 57% of program costs



Medicaid Payments per Aged and Disabled Enrollees are $10,085 *and* $13,820, *respectively, compared to $2,462 for children and $2,973 for adults.*

e: Kaiser State Health Facts, Oklahoma.

Oklahoma Hospital Association

Evaluations of SoonerCare Choice

SoonerCare Choice achieves mixed results on indicators of quality of care and health outcomes.

- **Preventive Screenings & Health Management:** Breast/cervical cancer screening rates, cholesterol management rates, and performance on all adult comprehensive diabetes measures are well below national average.
- **Emergency Department Utilization:** While the state has achieved some reductions, ED utilization rates remain high, especially for the disabled.

s: Leavitt Partners: “Covering the Low-Income, Uninsured in Oklahoma”; PHPC, “SoonerCare Choice Program Independent Evaluation,” Sept. 2014

Broadening Coverage Reduces Uncompensated Care Costs

- In 2012, Oklahoma hospitals absorbed **$547 million in uncompensated care costs**, which represented 6.1% of Oklahoma hospitals' total expenses.

- The cost of treating **the uninsured disproportionately affects rural hospitals.**
  - Uncompensated care accounted for 10-17% of the expenses for 20 rural Oklahoma hospitals (compared to the 6.1% state average).

- **Rural hospitals are less able to shift costs** to insured patients given their payer mix.

Sources: American Hospital Association/OHA/OSDH Annual Cooperative Hospital Survey

OHA
Oklahoma Hospital Association

Investment in Coverage Preserves Access in Rural Communities

Median Operating Margin
Oklahoma Hospitals

	2005	2006	2007	2008	2009	2010	2011	2012
Rural hospitals	3.2%	2.9%	2.4%	0.2%	-2.2%	-1.8%	-1.4%	-1.0%
All hospitals	4.9%	5.1%	3.3%	1.7%	0.2%	0.6%	2.4%	2.3%

Sources: CMS Healthcare Cost Report Information System

Behavioral Health Is a Key Investment Area

Top 10 Diagnoses for Readmissions 2011

Medicaid
Mood disorders
Schizophrenia, other psychosis
Diabetes mellitus
Other complications of pregnancy
Alcohol-related disorders
Early or threatened labor
Congestive Heart Failure*
Septicemia (except labor)*
COPD and bronchiectasis*
Substance-related disorders

Four of the top 10 diagnoses related to readmissions are for behavioral health conditions.

Source: 2011, Data, Healthcare Cost and Utilization Project (HCUP). Agency for Healthcare Research and Quality (AHRQ). http://www.ahrq.gov/research/data/hcup/index.html

Coverage Increases Resources for Behavioral Health

- **Federal dollars are available to pay for mental health and substance abuse services currently funded with state dollars.**
  - Increasing coverage would result in the federal government covering **$34 M** of **Department of Mental Health and Substance Abuse** expenditures annually.
  - The Department would then be able to use the freed up state dollars on other services that are not reimbursable by the federal government, e.g. social supports.
- The **Department of Corrections** would save **$11 M** in spending on prisoner hospitalizations.
  - Individuals discharged from prisons become eligible for Medicaid.
  - Access to physical and behavioral health services during transition could help prevent recidivism.

In addition to these savings, the state would save **$2.4 M** in **Department of Health** expenditures for a **total of $48.2 M in annual state savings.**

Source: OHCA, as described in Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma";

Investing in Coverage Provides a High Rate of Return

- **An additional $8.6 B in federal funds** flows to the state over 10 years.
- **13,211* new jobs** in Oklahoma are created over 10 years.
- **$50 M** in state expenditures for health services are replaced by federal dollars annually, including a significant amount for behavioral health services.
- **Uncompensated care costs** for hospitals, physicians, and other providers **go down**, particularly benefiting rural communities.
- **Cost shifting** between payers and between the uninsured and the insured **is reduced.**

*Based on median coverage take-up rate.

Sources: Urban Institute; Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma"

Goals for Oklahoma's Investment in Health Care

- ✓ **Improve Quality, Outcomes, Value and Transparency**
- ✓ **Improve Access**
- ✓ **Contain Costs**
- ✓ **Improve Sustainability**

Goals for the State's Health Care Investment

1. Improve quality, outcomes and value by holding providers accountable through value based purchasing models emphasizing care coordination and transparency.

2. Improve access by broadening coverage, identifying gaps in provider capacity and targeting resources more effectively.

3. Contain costs by targeting medically complex, high-cost populations (e.g. individuals with co-morbid physical and behavioral health conditions) and reducing unnecessary emergency department visits and potentially preventable admissions and readmissions.

4. Improve budget certainty and sustainability of the Medicaid program.

Building Blocks for an Oklahoma Plan

Payment & Delivery System Reform

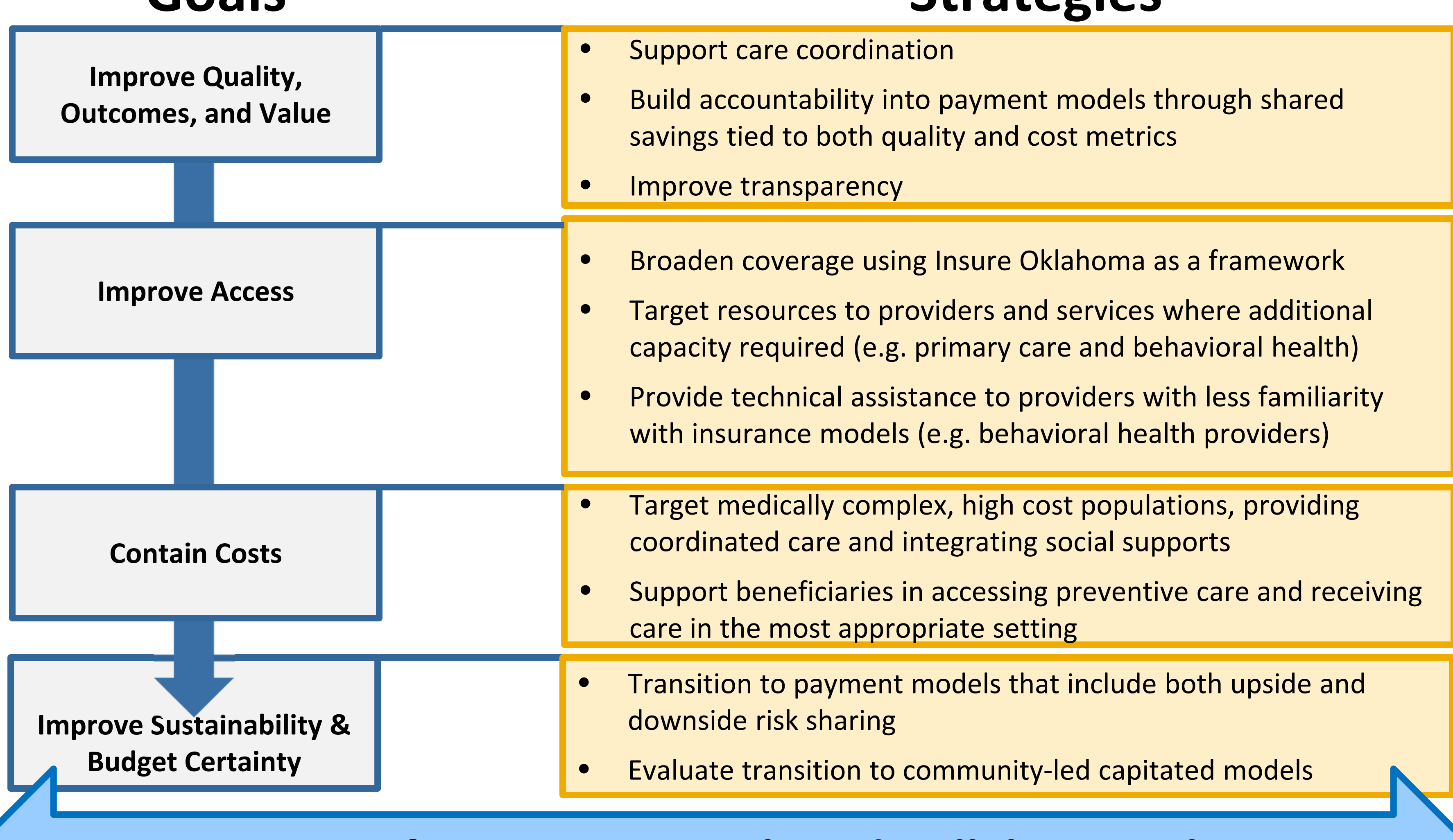
Coverage Reform

Payment & Delivery System Reform	Coverage Reform
Improve quality & contain costs by moving from volume-based to value-based purchasing.	Build on Insure Oklahoma
Reduce unnecessary utilization, including ER visits and hospitalizations, through enhanced care coordination and access to primary care.	Engage the private sector
Integrate services for high cost, high need beneficiaries with physical and behavioral health comorbidities.	Require personal responsibility
	Incent work and education
	Ensure sustainability

Enables budget predictability for the state

Payment & Delivery System Reforms

Oklahoma's Health Care Investment Goals & Strategies



Vehicles to Coordinate Care for Medicaid Beneficiaries

Patient-Centered *Medical* Homes

- A PCMH is a type of medical home that **centers around primary care physicians**, with incentives to coordinate patients' care across multiple providers (including hospitals, specialty, and community services and supports).
- States use various payment methodologies in PCMHs, including enhanced fee for service (FFS) rates, per member per month capitation rates, and shared savings.
- PCMHs may be implemented under the State Plan or under a waiver, depending on the features of the model.

Health Homes

- Medicaid Health Home **centers around the social service supports and care coordination** and targets Medicaid enrollees with chronic conditions or serious mental illness.
- Health homes provide:
    - Comprehensive care management and care coordination
    - Health promotion and patient education
    - Comprehensive transitional and follow-up care
    - Patient & family support
    - Referral to community & social supports
- States have flexibility in determining the payment methodology for health home services.
- States may receive 90% enhanced federal match for the first two years of health home services.

Proposed Building Blocks of Reform in Oklahoma

Medical Homes

- Expand patient-centered medical homes (PCMHs) to all Medicaid beneficiaries
- Establish linkages between and among PCMHs, hospitals and FQHCs
- Build on Health Access Networks to support medical home development
- PCMHs, partner hospitals and FQHCs eligible for shared savings

Health Homes

- Expand health homes for individuals with behavioral health conditions
- Establish health homes for individuals with chronic conditions
- Establish linkages with hospitals and FQHCs
- Health homes, partner hospitals and FQHCs eligible for shared savings

Community-Led Accountable Care Models

- Enroll beneficiaries in community-led accountable care models
- PCMHs and health homes provide care coordination and support services; foundation of accountable care
- Payment model developed over three years beginning with shared savings and transitioning to full capitation

Transition to Provider Risk-Bearing Models Over Time

Broaden Coverage in Oklahoma

Increased Coverage Facilitates Medicaid Reform

- Reduces churn between types of coverage and uninsurance
- Enables the management of care for individuals – directing them to preventive services and the most appropriate setting of care
- Reduces cost shifting across payers and employers
- Improves access to care and retains providers in the Medicaid delivery system
- Facilitates financial sustainability for providers who are particularly vulnerable to high rates of uninsured patients (e.g. rural providers)
- Enables Oklahoma to secure federal dollars to support transformation efforts

Current Coverage Programs: SoonerCare

SoonerCare Choice is a primary care case management program where individuals are assigned to a medical home through which they receive primary care and care coordination services. High need beneficiaries receive additional care coordination and management support through Health Assistance Networks and the Health Management Program. Most children, parents, and many non-Medicare aged, blind and disabled (ABD) beneficiaries are enrolled in this program.

SoonerCare Traditional is a fee-for-service program that provides the standard Medicaid benefit package through a statewide network of providers. Individuals in long term care (LTC) facilities, dual eligibles, and LTC waiver populations are enrolled in this program. The primary difference between SoonerCare Choice and SoonerCare Traditional is that individuals in the Traditional plan are not enrolled in medical homes and physician visits are capped (children excluded).

Oklahoma Cares provides full SoonerCare benefits for women receiving treatment for breast and cervical cancer. Women who earn <185% Federal Poverty Level (FPL) and are less than 65 are eligible.

SoonerPlan covers only family planning services for men and women up to 133% FPL.

Current Coverage Programs: Insure Oklahoma

Insure Oklahoma offers **premium assistance for employer-sponsored insurance (ESI)** to individuals who make <200% FPL and work at eligible employers. Under this plan, employees, the state, and the employer all share in the cost of private health plan coverage for the employee.

Eligible individuals who make <100% FPL may purchase subsidized health insurance coverage through the Insure Oklahoma **Individual Plan (IP)**. Enrollees in the plan pay up to 20% of the premium on a sliding scale, which is subject to a cap of 4% of gross income. The Individual Plan is administered by the Oklahoma Health Care Authority.

The state's portion of Insure Oklahoma is financed by a sales tax on tobacco products; federal Medicaid matching funds cover the balance.

The program is authorized under an 1115 waiver. Without a waiver extension, it will end December 31, 2015.

Closing the Coverage Gap: Newly Eligible Adults

NEWLY ELIGIBLE ADULTS

- Childless adults with income below 138% FPL ($16,105)
- Parents with incomes between 42% - 138% FPL *(Example: family of two with parent and child, income between $6,606-$21,707)*
- Estimated 233,334 individuals would enroll in coverage over 10 years based on medium take-up rate

Source: Kaiser State Health Facts; Leavitt Partners: "Covering the Low-Income, Uninsured in Oklahoma"

Covering the New Adults: Building on Insure Oklahoma

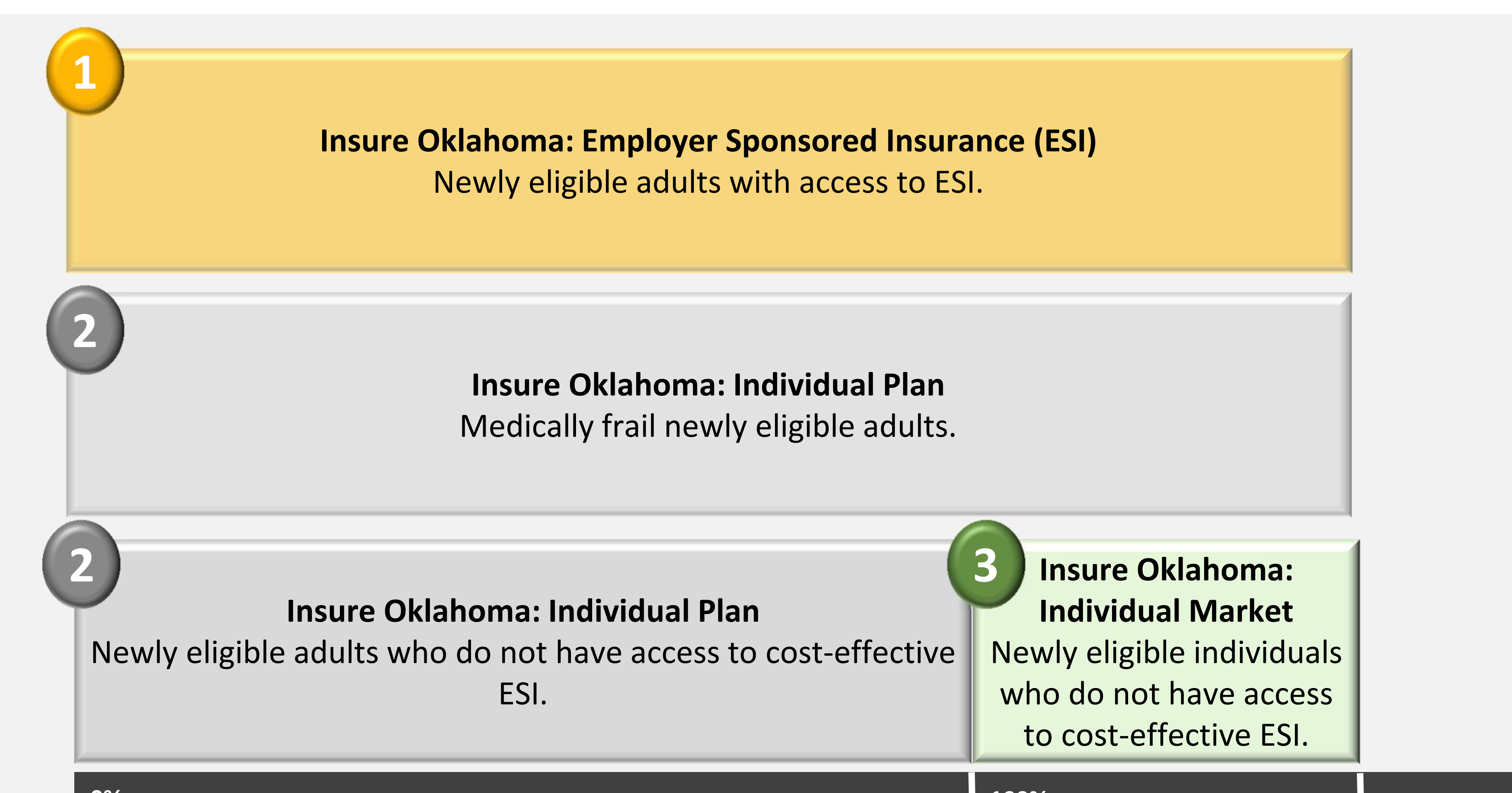
- Newly eligible adults with incomes up to 138% FPL with access to cost-effective employer-sponsored insurance (ESI) would be eligible for **Insure Oklahoma: ESI.**

- Newly eligible adults with incomes between 0-100% FPL without access to cost-effective ESI would be eligible for **Insure Oklahoma: Individual Plan.**

- Newly eligible adults with incomes between 100-138% FPL without access to cost-effective ESI would be eligible to enroll in commercial health plans on the individual market.

- Medically frail newly eligible adults with incomes up to 138% FPL would enroll in **Insure Oklahoma: Individual Plan**.

Insure Oklahoma: Proposed Coverage Solution



Coverage Proposal: Rationale and Considerations

Insure Oklahoma

1. **Insure Oklahoma: ESI** builds on the existing premium assistance program. Employer funding stays in the system.

2. **Insure Oklahoma: Individual Plan** builds on existing program and incorporates personal responsibility features for newly eligible adults, including cost sharing and non-coverage of non-emergent use of the ER, and payment and delivery system reforms holding providers accountable for improved quality and outcomes with a particular focus on high need beneficiaries.

3. **Insure Oklahoma: Individual Market** provides premium assistance to individuals enrolled in commercial health plans coupled with personal responsibility features including premiums and cost-sharing.

Examples of the Newly Insured Adults

Rachel

Single Working Mother
Annual Income: $12,584

Rachel is a single mom who works part-time for a large company. While pregnant, she was covered through SoonerCare Choice. However, 60 days post-partum her income exceeded the limit for SoonerCare Choice. Her employer is too large to participate in Insure Oklahoma and she cannot afford her employer's premiums. Her daughter, Anne, is enrolled in SoonerCare. (IO: ESI)

Rob, Janet, & Peter

Family with Working Parent
Annual Income: $17,811

Rob works full time making $9/hour for an employer in Texas that does not offer insurance. Janet stays at home with their 1-year-old son, Peter. Peter is enrolled in SoonerCare Choice. Rob and Janet are uninsured. Their income is too high to qualify for SoonerCare, and because Rob's employer is based out-of-state, he and Jan are not eligible for Insure Oklahoma. (IO:IP)

Jim

Working Adult
Annual Income: $11,086

Jim works for a small construction company. His employer used to offer health insurance for which employees paid 50% of the cost of the premiums. The company can no longer afford to offer insurance. If Jim's employer were enrolled in Insure Oklahoma, both Jim and his employer would receive assistance toward the cost of the premiums, with the state covering at least 60%. (IO: ESI)

Donna

Unemployed Adult
Annual Income: $0

Donna recently lost her job as a result of missed days due to treatments for liver cancer. Because of the illness, she is not currently looking for work. She is not eligible for SoonerCare due to her type of cancer (i.e., not breast or cervical cancer). Meanwhile, she is not eligible for Insure Oklahoma because she is not working or looking for work. (IO: IP)

Features of Oklahoma's Coverage Approach

Benefits. Alignment of the alternative benefit plan for newly eligible adults with the benefits offered by QHPs to the maximum extent possible.

Premiums and Cost-Sharing. Targeted use of premiums and cost sharing for individuals with incomes above 100% FPL.

Healthy Behavior Incentives. Incentives for meeting health or wellness standards, including elimination or reduction of co-pays or premiums.

Work and Education Referrals. Referrals to job training and placement programs (e.g., www.OKJobMatch.com) for unemployed individuals with incentives for participation.

State Protections. Use of a trust fund and a provider fee backstop to cover the non-federal share of the newly eligible; adoption of a provision to sunset coverage should the federal match rate go down.

States Cover ABP Benefits for New Adults at Enhanced Match

ALTERNATIVE BENEFIT PLAN (ABP)

- 10 Essential Health Benefits
    - Ambulatory patient services
    - Emergency services
    - Hospitalization
    - Maternity and newborn care
    - Mental health and substance use disorder services, including behavioral health treatment
    - Prescription drugs
    - Rehabilitative and habilitative services and devices
    - Laboratory services
    - Preventive and wellness services and chronic disease management
    - Pediatric services, including oral and vision care
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19 and 20 year olds
- Non-emergency medical transportation

YEAR	ENHANCED FEDERAL MATCHING RATE NEWLY ELIGIBLE ADULTS UP TO 138% FPL	
	State Share	*Federal Share*
2014	0%	100%
2015	0%	100%
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020+	10%	90%

Covered Benefits for Newly Eligible Adults

Coverage Vehicle

Insure Oklahoma: ESI

Insure Oklahoma: Individual Plan

Insure Oklahoma: Individual Market

Benefit Package

- Alignment of benefits with QHPs to the maximum extent possible with no coverage of non-emergent use of the emergency department
- Medically frail new adults choose between the Insure Oklahoma Individual Plan benefit package and the traditional Medicaid benefit package
- Enhanced federal match for all covered services

Personal Responsibility: Premiums and Cost Sharing

Premiums

- Individuals with incomes 100% to 138% FPL subject to a premium up to 2% of household income
- Failure to pay premium for 90 days results in disenrollment
  - Re-enrollment not tied to repayment of back premiums
  - Unpaid premiums are a collectible debt
  - Consistent with PA's approach
- Individuals with incomes <100% FPL have no premium obligation

Cost Sharing

- Cost sharing consistent with federal rules for newly eligible adults 100-138% FPL (*see appendix*)
- Medicaid cost sharing for individuals >100% FPL generally aligns with QHP cost sharing for individuals <150% FPL

Incentives for Healthy Behaviors, Work Search & Education

Healthy Behavior Standards

- Reduction in cost sharing obligation or premiums for meeting healthy behavior standards, such as attending smoking cessation counseling or receiving all recommended preventive screenings

Work & Education Referrals

- Unemployed individuals referred to job training or work placement programs, e.g., www.OKJobMatch.com
- May include vouchers to reduce premiums or cost sharing for participation

Protections Used in Other States

Trust Fund

- Savings generated from increased coverage set aside to offset the State's share beginning in 2017.
- Sources of savings: cost of services for new adults currently funded with state dollars (e.g., mental health and substance abuse programs) and enhanced match for coverage of some existing eligibility groups e.g., Insure Oklahoma.

Provider Fee Backstop

- Revenue generated from provider fee may be used to cover a portion of the State's share for increased coverage if cost for new adults exceeds an established target.

Sunset Provision

- Termination of coverage for new adults if Congress reduces the federal share authorized by the Affordable Care Act (federal share is 100% through 2016 and decreases overtime until it reaches 90% in 2020).

Time Frame for Implementation of Proposals

Current	Phase 1 (2015-2016)	Phase 2 (2017-2020)
• Multi-stakeholder process to develop specific coverage and reform features and develop metrics for success.	• Expand Insure Oklahoma: ESI • Expand Insure Oklahoma: Individual Plan • Launch Insure Oklahoma: Individual Market • Expand PCMHs and develop shared savings program • Expand health homes and develop shared savings program • Develop provider-led accountable care model(s) and launch initially with FFS and shared savings	• Transition provider-led model(s) to capitated payments, potentially requiring a health plan or other state license.

It is possible….

- ✓ For providers to transition from the 1st Curve to the 2nd Curve.
- ✓ For public/private partnerships to forge models for higher levels of health care services.
- ✓ To improve value and outcomes from Oklahoma's investment in health care.
- ✓ To broaden coverage and improve the health of all Oklahomans.

Thank You…

Comments or Questions?

Appendix

Medicaid Premium & Cost-Sharing Rules

	< 100% FPL	100% - 149% FPL	≥ 150% FPL
Maximum Allowable Medicaid Premiums and Cost-Sharing			
Aggregate Cost-Sharing Cap	5% household income	5% household income	5% household income
Premiums	Not allowed	Not allowed	Permitted, subject to aggregate cap
Maximum Service-Related Co-pays/Co-Insurance			
Outpatient services	$4	10% of cost the agency pays	20% of cost the agency pays
Non-emergency ER	$8	$8	No limit
Rx Drugs	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: 20% of cost the agency pays
Institutional	$75 per stay	10% of total cost the agency pays for the entire stay	20% of total cost the agency pays for the entire stay

- Specific services are exempt from cost-sharing, including emergency services, family planning and pregnancy-related services
- Specific populations are exempt from cost-sharing requirements (e.g., pregnant women, spend-down beneficiaries, and individuals receiving hospice). However, exempt individuals may be charged cost-sharing for non-preferred drugs and non-emergency use of the emergency room
- Services may not be denied for individuals who fail to make co-payments if their income <100% FPL; services may be denied for those with incomes >100% FPL
- If non-preferred drugs are medically necessary, preferred drug cost sharing applies

About Manatt Health

Our mission is to support clients transforming America's health system by increasing coverage and access and creating new ways of organizing, paying for and delivering care.

- **Interdisciplinary team of consultants and attorneys**
- **Thought leadership partnering with foundations, associations and policy makers**

What we are working on now:

- Medicaid transformation, including payment and delivery system reform and coverage solutions
- Multi-payer and payer/provider alignment
- Health reform opportunities (ACO, CMMI, Medicaid Waivers, Value-Based Purchasing, Duals Programs)
- Formation of next generation health care systems
- Population health management and sub-acute strategies
- Physical & behavioral health integration

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers per ~~OAC~~ Oklahoma Administrative Code (OAC) 317:35-9-5 and ~~as defined in~~ per Section 1915(c) of the Social Security Act. The specific waivers are the In-Home Supports Waiver (IHSW) for Adults, the In-Home Supports Waiver (IHSW) for Children, the Community Waiver, and the Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through ~~a~~ an HCBS Waiver and his or her family or guardian are responsible for:

(1) accessing, with the assistance of OKDHS staff, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under a HCBS Waiver program;

(2) cooperating in the determination of medical and financial eligibility, including prompt reporting of changes in income or resources; ~~and~~

(3) choosing between services provided through a HCBS Waiver and institutional care~~.~~ ; and

(4) reporting to DHS within 30 calendar days of moving any changes in address or other contact information.

(c) **Waiver Eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in ~~paragraph~~ (1) of this Subsection and the criteria for one of the Waivers established in ~~Subparagraph~~ (1) (A), (B), or (C) of this Subsection.

(1) Services provided through ~~a~~ an HCBS Waiver are available to Oklahoma residents meeting SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in ~~subsection~~ (a) of this Section, a person must meet conditions per OAC 317:35-9-5. The individual must be determined financially eligible for SoonerCare per OAC 317:35-9-68. The SoonerCare eligible individual may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, residential care facility ~~as described in~~ per Section 1-819 of Title 63 of

Oklahoma Statutes, or Intermediate Care facility for ~~persons with mental retardation (ICF/MR)~~ individuals with intellectual disabilities (ICF/IID). The individual may not be receiving ~~DDSD~~ Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

(A) **In-Home Supports Waivers.** To be eligible for services funded through the In-Home Supports Waiver (IHSW), a person must:

(i) meet all criteria ~~given~~ listed in ~~subsection~~ (c) of this Section; and

(ii) be determined to have a disability and a diagnosis of intellectual disability by the Social Security Administration (SSA); or

(iii) be determined to have a disability, and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA Level of Care Evaluation Unit (LOCEU);

(iv) be three years of age or older;

(v) be determined by the OHCA/LOCEU to meet the ~~ICF/MR~~ ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122;

(vi) reside in:

(I) the home of a family member or friend;

(II) his or her own home;

(III) ~~an OKDHS Children and Family Services Division (CFSD)~~ a DHS Child Welfare Service (CWS) foster home or shelter; or

(IV) a ~~CFSD~~ CWS group home; and

(vii) have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare resources available to the individual, and with HCBS Waiver resources ~~that are~~ within the annual per capita Waiver limit agreed between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(B) **Community Waiver.** To be eligible for services funded through the Community Waiver, the person must:

(i) meet all criteria ~~given~~ listed in ~~subsection~~ (c) of this Section;

(ii) be determined to have a disability and a diagnosis of intellectual disability by the SSA; or

(iii) have an intellectual disability as defined in

the Diagnostic and Statistical Manual of Mental Disorders or a related condition by ~~the DDSD~~ DDS and ~~to~~ be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(iv) be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA/LOCEU; and

(v) be three years of age or older; and

(vi) be determined by the OHCA/LOCEU, to meet the ~~ICF/MR~~ ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122; and

(vii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the ~~DDSD Division Director~~ DDS director or designee.

(C) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the person must:

(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(ii) meet all criteria for HCBS Waiver services ~~given~~ listed in ~~subsection~~ (c) of this Section; and

(iii) be determined to have a disability and a diagnosis of intellectual disability by SSA; or

(iv) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition per OAC 317:35-9-45 by ~~DDSD~~ DDS and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(v) have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(vi) meet ~~the ICF/MR~~ ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122 by the OHCA/LOCEU.

(2) The person desiring services through any of the Waivers listed in ~~subsection~~ (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, by a licensed ~~Psychologist or State staff supervised by a licensed~~

~~Psychologist, current within 12 months of requested approval date,~~ psychologist that includes:

(i) a full scale functional and/or adaptive assessment; and

(ii) a statement of age of onset of the disability; and

(iii) intelligence testing that yields a full scale intelligence quotient.

(I)Intelligence testing results obtained at 16 years of age or older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between 7 to 16 years of age are considered current for four years when the full scale intelligence quotient is less than 40, and for two years when the intelligence quotient is 40 or above.

(II) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;

(B) a social service summary, current within 12 months of requested approval date, that includes a developmental history; and

(C) a medical evaluation current within 90 calendar days of requested approval date; and

(D) a completed ~~ICF/MR~~ ICF/IID Level of Care Assessment form (LTC-300); and

(E) proof of disability according to SSA guidelines. If a disability determination ~~had~~ has not been made by SSA, ~~the~~ OHCA/LOCEU may make a disability determination using the same guidelines as SSA.

(3) ~~The~~ OHCA reviews the diagnostic reports listed in ~~paragraph~~ (2) of this subsection and makes a determination of eligibility for ~~DDSD~~ DDS HCBS Waivers.

(4) For individuals who are determined to have an intellectual disability or a related condition by ~~DDSD~~ DDS in accordance with the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, ~~DDSD~~ DDS reviews the diagnostic reports listed in ~~paragraph~~ (2) of this subsection and, on behalf of the OHCA, makes a determination of eligibility for ~~DDSD~~ DDS HCBS Waiver services and ~~ICF/MR~~ ICF/IID level of care.

(5) A determination of need for ~~ICF/MR~~ ICF/IID Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When ~~State DDSD~~ state DDS resources are unavailable for new persons to be added to services funded through ~~a~~ an HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order, based on the date of receipt of a written request for services on Form 06MP001E, Request for Developmental Disabilities Services, and required documentation per Form 06MP001E, for initial consideration of potential eligibility.

(2) The Request for Waiver Services List for persons requesting services provided through ~~a~~ an HCBS Waiver is administered by ~~DDSD~~ DDS uniformly throughout the state.

(3) An individual is removed from the Request for Waiver Services List ~~if~~ when the individual:

(A) is found to be ineligible for services;

(B) cannot be located by ~~OKDHS~~ DHS;

(C) fails to respond or does not provide ~~required~~ requested information to ~~OKDHS~~ DHS;

(D) is not a resident of the state of Oklahoma at the time of requested Waiver approval date; or

(E) declines an offer of Waiver services

(4) An individual removed from the Request for Waiver Services List because the individual could not be located by DHS may later submit to DDS written request to be returned to the Request for Waiver Services List at the same chronological place on the Request for Waiver Services List that the individual had prior to removal, provided that the individual was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, ~~DDSD~~ DDS ensures action regarding a request for services occurs within 45 calendar days. ~~If~~ When action is not taken within the required 45 calendar days, the applicant may seek resolution ~~as described in~~ per OAC 340:2-5.

(1) Applicants are allowed 60 calendar days to provide information requested by ~~DDSD~~ DDS to determine eligibility for services.

(2) ~~If~~ When requested information is not provided within 60 calendar days, the applicant is notified ~~that~~ the request ~~has been~~ was denied, and the individual is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through ~~a~~ an HCBS Waiver occurs in chronological order from the Request for Waiver Services List in accordance with ~~subsection~~ (d) of this Section based on the date of ~~DDSD~~ DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or ~~his or her legal~~

~~guardian~~ the individual acting on the member's behalf, and upon determination of eligibility, in accordance with ~~subsection~~ (c) of this Section. Exceptions to the chronological requirement may be made when:

(1) an emergency situation exists in which the health or safety of the person needing services, or of others, is endangered, and there is no other resolution to the emergency. An emergency exists when:

(A) the person is unable to care for himself or herself and:

(i) the person's caretaker, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:

(I) is hospitalized;

(II) ~~has~~ moved into a nursing facility;

(III) is permanently incapacitated; or

(IV) ~~has~~ died; and

(ii) there is no caretaker to provide needed care to the individual; or

(iii) an eligible person is living at a homeless shelter or on the street;

(B) ~~the OKDHS~~ DHS finds ~~that~~ the person needs protective services due to experiencing ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so~~.~~ ;

(2) the Legislature has appropriated special funds with which to serve a specific group or a specific class of individuals under the provisions of ~~a~~ an HCBS Waiver;

(3) Waiver services are required for people who transition to the community from a public or ~~ICF/MR~~ ICF/IID who are children in the State's custody receiving services from ~~OKDHS~~ DHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ~~ICF/MR~~ ICF/IID and enters the Waiver;

(4) individuals subject to the provisions of Public Law 100-

203 residing in nursing facilities for at least 30 continuous months prior to January 1, 1989,and who are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted pursuant to the provisions of 42 CFR 483.100 et seq to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between ~~DDSD~~ DDS HCBS Waiver programs.** A person's movement from services funded through one DDS-administered HCBS Waiver, to services funded through another ~~DDSD-administered~~ DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes 18 years of age, services through the IHSW for adults become effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a member has critical health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the ~~DDSD Director~~ DDS director or designee; and

(B) funding is available per OAC 317:35-9-5.~~.~~

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization has been within the per capita allowance of the IHSW.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA/LOCEU when a determination of disability has not been made by the Social Security Administration. The OHCA/LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders. ~~DDSD~~ DDS may require a new ~~diagnostic~~ psychological evaluation ~~in accordance with paragraph (c)(2) of this subsection~~ and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status

~~determined under paragraph (c)(2) of this Section~~ has been noted.

(i) **HCBS Waiver services case closure.** Services provided through ~~a~~ an HCBS Waiver are terminated, when:

(1) ~~when~~ a member or ~~the member's legal guardian~~ the individual action on the member's behalf chooses to no longer receive Waiver services;

(2) ~~when~~ a member is incarcerated;

(3) ~~when~~ a member is financially ineligible to receive Waiver services;

(4) ~~when~~ a member is determined by the Social Security Administration to no longer have a disability qualifying the individual for services under these Waivers;

(5) ~~when~~ a member is determined by the OHCA/LOCEU to no longer be eligible;

(6) ~~when~~ a member moves out of state, or the custodial parent or guardian of a member who is a minor moves out of state;

(7) ~~when~~ a member is admitted to a nursing facility, ~~ICF/MR~~ ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive calendar days;

(8) ~~when~~ the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process ~~as described in~~ per OAC 340:100-5-50 through 340:100-5-58;

(9) ~~when~~ the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of ~~OKDHS~~ DHS policy or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have not been effective;

(10) ~~when~~ the member is determined to no longer be SoonerCare eligible; or

(11) ~~when~~ there is sufficient evidence ~~that~~ the member or ~~his/her legal representative~~ the individual acting on the member's behalf has engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) ~~when~~ the member or ~~his/her legal representative~~ the individual action on the member's behalf either cannot be located, has not responded to, or has not allowed case management to complete plan development or monitoring activities as required by policy and the member or ~~his/her legal representative~~ the individual action on the member's

behalf:

(A) does not respond to the notice of intent to terminate; or

(B) the response prohibits ~~case management (the case manager)~~ the case manager from being able to complete plan development or monitoring activities as required by policy;

(13) ~~when~~ the member or ~~his/her legal representative~~ the individual action on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) ~~when~~ it is determined that services provided through ~~a~~ an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance ~~that~~ the member's health, safety, and welfare can be maintained without Waiver supports;

(15) ~~when~~ the member or ~~his/her legal representative~~ the individual acting on the member's behalf fails to cooperate with service delivery;

(16) ~~when~~ a family member, ~~authorized representative~~ the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official DHS representatives ~~of OKDHS~~; or

(17) ~~when~~ a member no longer receives a minimum of one Waiver service per month and ~~DDSD~~ DDS is unable to monitor member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:

(1) the situation resulting in case closure of a Hissom class member is resolved;

(2) a member is incarcerated for 90 calendar days or less;

(3) a member is admitted to a nursing facility, ~~ICF/MR~~ ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 calendar days or less; or

(4) a member's SoonerCare eligibility is re-established within 90 calendar days of the date of SoonerCare ineligibility.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 5. MEMBER SERVICES

317:40-5-3. Agency companion services

(a) Agency companion services (ACS)are:

(1) ~~are~~ provided by agencies that have a provider agreement with the Oklahoma Health Care Authority (OHCA);

(2) ~~provide a~~ provided by independent contractors of the provider agency and provide a shared living arrangement developed to meet the specific needs of the member that includes ~~a live-in companion providing~~ supervision, supportive assistance, and training in daily living skills, and integrates the member into the shared experiences of a family ~~provided~~ in a ~~shared~~ home owned or rented by the ~~member,~~ companion~~, or in a mutually rented or owned home~~;

(3) ~~are~~ available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under ~~the age of~~ 18 years of age may be served with approval from the ~~DDSD~~ Oklahoma Department of Human Services Developmental Disabilities Services (DDS) director or designee;

(4) ~~are~~ based on the member's need for residential services per ~~OAC~~ Oklahoma Administrative Code(OAC) 340:100-5-22 and support as described in the member's Individual Plan (Plan), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:

(1) must ~~be employed by or~~ have an approved home profile per OAC 317:40-5-3 and contract with a provider contract with a provider agency approved by ~~the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD)~~DDS;

(2) may provide companion services for one member. Exceptions to serve as companion for two members may be approved by the ~~DDSD~~ DDS director or designee. Exceptions may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;

(3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the ~~DDSD~~ DDS director or designee;

(4) may not provide companion services to more than two members at any time;

(5) household may not serve more than three members through

any combination of companion or respite services;

(6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5.

~~(A) Employment as an agency companion is the companion's primary employment.~~

~~(B) The companion may not have other employment when approved to serve two members regardless of the levels of support required by the members.~~

~~(C)~~ (A) The companion may have ~~other~~ employment when the:

(i) ~~the Team~~ personal support team (Team) documents and addresses all related concerns in the member's Plan;

(ii) ~~the other~~ employment is approved in advance by the ~~DDSD~~ DDS area manager or designee; and

(iii) ~~the~~ companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and

(iv) ~~the~~ companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.

~~(D)~~(B) If, after receiving approval for ~~other~~ employment, authorized ~~DDSD~~ DDS staff determines the ~~other~~ employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within 30 calendar days:

(i) ~~the other~~ his or her employment; or

(ii) his or her ~~employment~~ contract as an agency companion.

~~(E)~~(C) Homemaker, habilitation training specialist, and respite services are not provided for the companion to maintain other employment.

(c) Each member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's ~~salary~~ payment.

(1) Therapeutic leave:

(A) is a SoonerCare payment made to the contract provider to enable the member to retain services; and

(B) is claimed when the:

(i) ~~the~~ member does not receive ACS for 24 consecutive hours due to:

(I) a visit with family or friends without the companion;

(II) vacation without the companion; or

(III) hospitalization, regardless of whether the companion is present; or

(ii) ~~the~~ companion uses authorized respite time;

(C) is limited to no more than 14 consecutive, calendar days per event, not to exceed 60 days per Plan of Care (POC) year; and

(D) cannot be ~~accrued~~ carried over from one ~~Plan of Care (POC)~~ POC year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate ~~which~~ that is paid at the enhanced agency companion per diem rate.

(3) The provider agency pays the agency companion the ~~salary that~~ payment he or she would earn if the member were not on therapeutic leave.

(d) The companion may receive a combination of hourly or daily respite per POC year equal to 660 hours ~~for respite for the companion~~.

(e) Habilitation Training Specialist (HTS) services:

(1) may be approved by the ~~DDSD~~ DDS director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of not:

(A) sleeping at night; or

(B) working or attending employment, educational, or day services ~~with documented and continuing efforts by the Team~~;

(2) may be approved when a time-limited situation exists in which the ~~ACS~~ companion provider is unable to provide ACS, and the provision of HTS will maintain the placement or provide needed stability for the member, and must be reduced when the situation changes;

(3) must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers~~.~~; and

(4) must be documented by the Team and the Team must continue efforts to resolve the need for HTS.

~~(f) The agency receives a provider rate based on the agency's service model. The AC rate for the:~~

~~(1) employer model includes funding for the provider agency for the provision of benefits to the companion; or~~

~~(2) contractor model does not include funding for the provider agency for the provision of benefits to the companion.~~

~~(g)~~ (f) The agency receives a ~~provider~~ daily rate based on the member's level of support. Levels of support for the member and corresponding payment are:

(1) determined by authorized ~~DDSD~~ DDS staff ~~in accordance with~~ per levels described in (A) through(D); and
(2) re-evaluated when the member has a change in agency companion providers ~~which~~ that includes a change in agencies or individual companion providers.

(A) **Intermittent level of support.** Intermittent level of support is authorized when the member:
(i) requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;
(ii) may be able to spend short periods of time unsupervised inside and outside the home; and
(iii) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(B) **Close level of support.** Close level of support is authorized when the member requires:
(i) ~~requires~~ regular, frequent and sometimes constant physical assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;
(ii) ~~requires~~ extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and
(iii) ~~requires~~ assistance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support.** Enhanced level of support is authorized when the member:
(i) is totally dependent on others for:
(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and
(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;
(ii) demonstrates ongoing complex medical issues requiring specialized training courses per OAC 340:100-5-26; or
(iii) has behavioral issues that requires a protective intervention plan (PIP) with a restrictive or intrusive procedure ~~as defined in~~ per OAC 340:100-1-2. The PIP must:

(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14;

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, or

(III) have received expedited approval per OAC 340:100-5-57.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:

(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system. The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

(g) Authorization for payment of Agency Companion Service is contingent upon receipt of:

(1) the applicant's approval letter authorizing ACS for the identified member;

(2) an approved relief and emergency back-up plan addressing a back-up location and provider;

(3) the Plan;

(4) the POC; and

(5) the date the member moved to the companion home.

(h)The Plan reflects the amount of room and board the member pays to the companion. The provider must use the room and board reimbursement payment to meet the member's needs. Items purchased with the room and board reimbursement payment includes housing and food. ~~If the amount exceeds $450, the additional amount must be:~~

~~(1) agreed upon by the member and, if~~ when ~~applicable, legal guardian;~~

~~(2) recommended by the Team; and~~

~~(3) approved by the DDSD~~ DDS ~~area manager or designee.~~

(i) If the amount exceeds $500, the additional amount must be:

(1) agreed upon by the member and, if when applicable, legal guardian;

(2) recommended by the Team; and
(3) approved by the DDSD DDS area manager or designee.

317:40-5-4. Selection of Agency Companion Services provider [REVOKED]

~~(a) The matching of the lifestyles and personalities of a companion and a service recipient and the overall compatibility of the companion with the service recipient are the most critical elements of the Agency Companion Services (ACS) program. The past and present relationship the service recipient has with the potential companion is the most important consideration in the companion selection process.~~
~~(b) In addition to considering the relationship between the service recipient and the companion, the case manager, the service recipient or legal guardian, and the service recipient's provider agency must reach consensus regarding the criteria listed in this Section before the approval process described in OAC 317:40-5-40 begins.~~
~~(1) The companion must have a relationship with the service recipient. Exceptions may be made by the service recipient's personal support team (Team) upon the recommendation of the Developmental Disabilities Services Division (DDSD) case manager, Division of Children and Family Services (DCFS) worker, or the Adult Protective Services (APS) worker, when appropriate.~~
~~(2) The companion must have the commitment and skills to meet the individual needs of the service recipient.~~
~~(3) The companion must understand the level of commitment required for the ACS program and how the commitment will affect the companion's personal life.~~
~~(4) The companion must understand how the commitment to the ACS program will impact the companion's family.~~
~~(5) The companion must demonstrate the ability to establish and maintain a positive relationship with the service recipient, particularly when stressful situations occur.~~
~~(6) The companion must demonstrate the ability to work collaboratively with others in the service process.~~
~~(7) Neither a service recipient's spouse nor the parent of a minor child may serve as that person's companion. A family member serving as companion must meet all requirements for the ACS program given in this Subchapter.~~
~~(8) The Chief Executive Officer (CEO) of a provider agency may not serve as a companion.~~

317:40-5-5. Agency Companion Services provider responsibilities

(a) ~~Providers of Agency Companion Services (ACS)~~ Companions are required to meet all applicable standards outlined in this

subchapter and competency-based training ~~described in OAC~~ per Oklahoma Administrative Code(OAC) 340:100-3-38. The provider agency ensures ~~that~~ all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, per OAC 340:100-3-27, for the companion, and ~~if~~ when warranted, revocation of approval of the companion.

(c) ~~In addition to the criteria given in OAC 317:40-5-4, the~~ The companion:

(1) ensures no other adult or child is cared for in the home on a regular or part-time basis, including other Oklahoma Department of Human Services ~~(OKDHS)~~ (DHS) placements, family members, or friends without prior written authorization from the ~~OKDHS~~ Developmental Disabilities Services ~~Division (DDSD)~~ (DDS)area manager or designee;

(2) meets the requirements of OAC 317:40-5-103~~, Transportation~~. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) delivers services in a manner that contributes to the member's enhanced independence, self-sufficiency, community inclusion, and well-being;

(5) participates as a member of the member's Team and assists in the development of the member's Individual Plan(Plan) for service provision;

(6) ~~with assistance from the DDSD case manager and the provider agency program coordination staff,~~ develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Plan~~;~~.

(A) The companion ~~documents and provides monthly data and health care summaries to the provider agency program coordination staff~~ may request assistance from the case manager or program coordinator.

~~(B) The agency staff provides monthly reports to the DDSD case manager or nurse.~~

(7) delivers services at appropriate times as directed in the Plan;

(8) does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA);

(9) is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;

(10) participates in, and supports visitation and contact with the member's natural family, guardian, and friends, ~~provided this~~ when visitation is desired by the member;

(11) obtains permission from the member's legal guardian, ~~if~~ when a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:

(A) traveling out of state;

(B) overnight visits; or

(C) involvement of the member in any publicity;

(12) serves as the member's health care coordinator per OAC 340:100-5-26;

(13) ensures the monthly room and board contribution received from the member is used toward the cost of operating the household;

(14) assists the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;

(15) works closely with the provider agency program coordination staff and the ~~DDSD~~ DDS case manager, to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;

(16) assists the member ~~in achieving~~ to achieve the member's maximum level of independence;

(17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;

(18) ensures ~~that~~ the member's confidentiality is maintained per OAC 340:100-3-2;

(19) supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;

(20) implements training and provides supports that enable the member to actively join in community life;

(21) does not serve as representative payee for the member without a written exception from the ~~DDSD~~ DDS area manager or designee~~;~~.

(A) The written exception is retained in the member's home record.

(B) When serving as payee, the companion complies ~~with the requirements~~ of OAC 340:100-3-4 requirements~~.~~;

(22) ensures the member's funds are properly safeguarded~~.~~;

(23) obtains prior approval from the member's representative payee when making a purchase of over $50~~.00~~ with the member's funds;
(24) allows ~~the~~ provider agency and DDS staff ~~and DDSD staff~~ to make announced and unannounced visits to the home;
(25) develops an Evacuation Plan, using ~~OKDHS~~ DHS Form 06AC020E, Evacuation/Escape Plan, for the home and conducts training with the member;
(26) conducts fire and weather drills at least quarterly and documents the fire and weather drills using Form 06AC021E, Fire and Weather Drill Record;
(27) develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using Form 06AC022E, Personal Possession Inventory;
(28) supports the member's employment program by:
(A) assisting the member to wear appropriate work attire; and
(B) contacting the member's employer as outlined by the Team and in the Plan; ~~and~~
(29) is responsible for the cost of ~~their~~ the member's meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution;
(30) for adults, reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, and/or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes to the DHS Office of Client Advocacy (OCA);
(31) for children, reports abuse, neglect, sexual abuse, or sexual exploitation per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Child Abuse and Neglect Hotline at 1-800-522-3511; ~~and~~
(32) follows all applicable rules promulgated by the Oklahoma Health Care Authority and ~~DDSD~~ DDS, including:
(A) OAC 340:100-3-40;
(B) OAC 340:100-5-50 through 100-5-58;
(C) OAC 340:100-5-26;
(D) OAC 340:100-5-34;
(E) OAC 340:100-5-32;
(F) OAC 340:100-5-22.1;
(G) OAC 340:100-3-27;
(H) OAC 340:100-3-38 ; ~~and~~
(I) OAC 340:100-3-34;
(33) is neither the member's spouse, nor when the member is a
minor child, the member's parent. A family member servicing

as companion must meet all requirements listed in this Subchapter; and
(34) is not the Chief Executive Officer of a provider agency.

317:40-5-6. Agency Companion ~~Services provider~~ contractor requirements

(a) The service recipient or legal guardian, the provider agency, ~~and~~ or the Oklahoma Department of Human ~~Services'~~ Services Developmental Disabilities Services ~~Division (DDSD)~~ (DDS)case manager may identify an applicant to be screened for approval to serve as ~~the~~ companion.

(b) Approval by ~~DDSD~~ DDS for a person to provide contracted Agency Companion Services (ACS) requires ~~that~~ the applicant:

(1) is 21 years of age or older;
(2) has attended the ~~DDSD~~ DDS or provider agency ACS orientation;
(3) ~~is employed by, or~~ contracts with~~,~~ a provider agency having a current contract with the Oklahoma Health Care Authority to provide ACS;
(4) submits the completed ~~DDSD~~ DDS application packet ~~in accordance with OAC~~ per Oklahoma Administrative Code (OAC) 317:40-5-40 within the required time period to designated ~~DDSD~~ DDS staff or the provider agency staff;
(5) cooperates with ~~the~~ designated ~~DDSD staff~~ DDS or ~~the~~ provider agency staff in the development and completion of the home profile approval process ~~described in~~ per OAC 317:40-5-40; and
(6) has completed all training required by OAC 340:100-3-38, including medication administration training, and all provider agency pre-employment training ~~as described in~~ per OAC 317:40-5-40.

317:40-5-9. Payment authorization for Agency Companion Services [REVOKED]

~~Authorization for payment of Agency Companion Services (ACS) is contingent upon receipt of:~~

~~(1) the applicant's approval letter authorizing ACS for the identified member;~~
~~(2) approved relief and emergency back-up plan;~~
~~(3) revised Individual Plan;~~
~~(4) revised Plan of Care; and~~
~~(5) placement of the member in the ACS home.~~

317:40-5-10. Agency companion services (ACS) annual review [REVOKED]

~~(a) In addition to the requirements of OAC 317:40-5-40, Oklahoma Department of Human Services Developmental Disabilities Services Division (DSSD) ACS staff annually review services provided by the companion to determine:~~

~~(1) continued compliance of the companion and home environment with DDSD and Oklahoma Health Care Authority rules;~~

~~(2) the satisfaction of the service recipient with the living arrangement; and~~

~~(3) continued use of the home.~~

~~(b) The annual review contains:~~

~~(1) written comments of the ACS staff from interviews with the service recipient that highlight the service recipient's thoughts and feelings about his or her companion and the ACS placement;~~

~~(2) written comments from the companion regarding program changes and issues of concern;~~

~~(3) summaries of the information obtained from the companion, the service recipient, the provider agency program coordination staff, and the DDSD case manager;~~

~~(4) recommendations for continued service;~~

~~(5) information received from Child Welfare or Adult Protective Services, if available; and~~

~~(6) identified areas of service that need improvement as well as areas of service that have been beneficial.~~

~~(c) A copy of the annual review is maintained in the DDSD area office with copies to the DDSD state office and the provider agency.~~

317:40-5-11. Termination of Agency Companion placement

(a) ~~Designated~~ <u>Oklahoma Department of Human Services</u> Developmental Disabilities Services ~~Division (DDSD)~~<u>(DDS)</u> staff may terminate an individual agency companion (AC) placement for reasons including, but not limited to <u>the</u>:

(1) ~~the~~ member's decision to move to a different residence;

(2) ~~the~~ request of the companion;<u>and</u>

(3) ~~the~~ <u>personal support team</u> ~~Team~~ determines the AC placement is no longer the most appropriate placement for the member;

~~(4) failure of the companion to complete tasks related to problem resolution, per OAC 340:100-3-27, as agreed;~~

~~(5) confirmed abuse, neglect, or exploitation of any person;~~

~~(6) breach of confidentiality;~~

~~(7) involvement of the companion in criminal activity, or criminal activity in the home;~~

~~(8) failure to provide for the care and well-being of the member;~~

~~(9) continued failure to implement the Individual Plan, per OAC 340:100-5-50 through 100-5-58;~~
~~(10) failure to complete and maintain training per OAC 340:10-3-38;~~
~~(11) failure to report changes in the household;~~
~~(12) failure or inability of the home to meet standards per OAC 317:40-5-40;~~
~~(13) continued failure to follow applicable Oklahoma Department of Human Services or Oklahoma Health Care Authority rules;~~
~~(14) decline of the companion's health to the point that he or she can no longer meet the needs of the member;~~
~~(15) employment by the companion without prior approval by the DDSD area programs manager for residential services; or~~
~~(16) domestic disputes which may result in emotional instability of the member.~~

(b) Upon termination of the placement~~:~~
~~(1) the property of the member or the state is removed immediately by the member or his or her designee; and~~
~~(2)~~ the Team meets to develop an orderly transition plan and arranges for the member's property to be moved as necessitated by the transition plan.

(c) ~~If an individual placement is terminated for reasons identified in (4)-(16) in this Section, DDSD staff will disapprove continued use of the companion.~~ Termination of an individual companion placement may also occur in conjunction with denial of a home profile per OAC 317:40-5-40.

317:40-5-13. Agency Companion Services provider agency responsibilities

(a) The agency providing Agency Companion Services (ACS) complies with Oklahoma Health Care Authority and Oklahoma Department of Human Services (DHS) policies and procedures governing all aspects of service provision.

(b) The provider agency is responsible for all ~~employee or~~ contract provider related activities detailed in this Subchapter.

(c) In the event the provider agency wishes to discontinue services immediately due to an emergency, the provider agency cooperates with the DHS Developmental Disabilities Services ~~Division (DDSD)~~ (DDS) to secure alternative services in the least restrictive environment.

(d) The provider agency ensures that services provided meet requirements of ~~OAC~~ Oklahoma Administrative Code (OAC) 340:100-5-22.1, unless different other requirements are stated in this Section.

(e) ~~If~~ When the provider agency serves as the member's

representative payee, the provider agency must adhere to ~~the requirements of~~ OAC 340:100-3-4.1 requirements.

(f) The provider agency acts immediately to remedy any situation posing a risk to the health, well-being, or provision of specified services to the member.

~~(1) In the event of such a risk, the provider agency immediately notifies DDSD of the nature of the situation and notifies DDSD upon the resolution of the threatening situation.~~

~~(2)~~ (1) The provider agency's program coordination staff ~~contacts and informs the DDSD case manager within 24 hours of an incident or injury. The provider agency~~ completes and submits incident and injury reports to ~~DDSD~~ DDS per ~~in accordance with~~ OAC 340:100-3-34.

~~(3)~~(2) A ~~companion~~ companion's contract is immediately terminated when a provider agency becomes aware ~~that~~ a companion's name appears on the Community Services Worker Registry per OAC 340:100-3-39.

(g) The provider agency ensures that only one member is served in a provider home. Exceptions may be approved by the ~~DDSD~~ DDS area manager or designee.

(h) ~~When the provider agency has knowledge of problems occurring in the placement, the provider agency's program coordination staff immediately schedules a meeting with the companion, the member, the member's legal guardian or advocate, the DDSD case manager and other appropriate DDSD staff to resolve the issues involved. If resolution of the issues does not occur at the meeting, any participant is to contact the DDSD area manager or designee and the provider agency for resolution.~~ Team members, including the provider agency program coordinator, companion, member, legal guardian, advocate, and DDS case manager work together to resolve issues to ensure the member's needs are met and the shared living arrangement is successful.

~~(i) When a change in the provider agency is requested by the member or the companion, all participants attempt to resolve the issues. No change in the provider agency occurs unless the DDSD area manager or designee agrees that all issues have been or discussed.~~

~~(j)~~(i) The ~~decision to remain or terminate services with the provider agency is the~~ choice of provider agency is made by the member or his or her legal guardian.

~~(k)~~(j) When a member transfers from a provider agency, the outgoing provider agency ensures ~~that~~ the member has a 30 calendar-day supply of medication and a seven-day supply of food, household ~~supplies~~, and personal supplies.

~~(l)~~(k) ~~The responsibilities of the provider~~ Provider agency's

program coordination staff responsibilities are to:

(1) ~~to~~ visit the provider home daily during the first week of placement;

(2) ~~to visit the home~~ make a minimum of three ~~times~~ face to face per month per OAC 340:100-5-22.1;

(3) ~~to~~ allow the ~~needs of the member~~ member's needs to determine the frequency of all other visits;

(4) ~~to~~ coordinate and submit quarterly reports to the provider agency for submission to the ~~DDSD~~ DDS area office; and

(5) ~~to~~ communicate regularly with the ~~DDSD~~ DDS case manager regarding any changes in the household or any other program issues or concerns.

~~(m)~~(l) The provider agency, ~~works with the~~ companion, member, and guardian ~~to~~ develop a back-up plan identifying respite staff~~.~~ and an alternate location in the event the home becomes uninhabitable. The back-up plan:

(1) is submitted to the ~~DDSD~~ DDS case manager for approval;

(2) describes expected and emergency back-up support and program monitoring for the home; and

(3) is incorporated into the member's Individual Plan (Plan).

~~(n)~~(m) The respite provider is:

(1) knowledgeable about the member;

(2) trained to implement the member's Plan;

(3) trained per OAC 340:100-3-38;

(4) responsible for the cost of ~~their~~ the member's meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.

~~(o)~~(n) The spouse or other adult residing in the home is considered a natural support and may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.12.

~~(p)~~(o) The spouse or other adult residing in the home cannot serve as paid respite staff.

317:40-5-40. Home profile process

(a) **Applicability.** This Section establishes procedures for the Developmental Disabilities Services (DDS) home profile process. A home profile is required for:

(1) agency companion services (ACS);

(2) specialized foster care (SFC) services;

(3) respite services delivered in the provider's home;

(4) approving services in a home shared by a non-relative provider and a member; and

(5) any other situation that requires a home profile.

(b) **Pre-screening.** Designated ~~Developmental Disabilities Services Division (DDSD)~~ (DDS) staff provides the applicant with program orientation and pre-screening information that includes, but is not limited to:

(1) facts, description, and guiding principles of the Home and Community-Based Services (HCBS) program;

(2) an explanation of:

(A) the home profile process;

(B) basic provider qualifications ~~of the provider~~;

(C) health, safety, and environmental issues; and

(D) training required per ~~OAC~~ Oklahoma Administrative Code (OAC) 340:100-3-38;

(3) the Oklahoma Department of Human Services ~~(OKDHS)~~(DHS) Form 06AC012E, Specialized Foster Care/Agency Companion Services Information Sheet;

(4) explanation of a background investigation conducted on the applicant and any adult or child living in the applicant's home.

(A) Background investigations are conducted at the time of application and include, but are not limited to:

(i) an Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search, including the Oklahoma Department of Public Safety (DPS), Sex Offender Registry and Mary Rippy Violent Offender Registries;

(ii) Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant and any adult members of the household;

(iii) search of any involvement as a party in a court action;

(iv) search of all ~~OKDHS~~ DHS records, including Child Welfare Services records and the Community Services Worker Registry;

(v) a search of all applicable out-of-state child abuse and neglect registries for any applicant or adult household member who has not lived ~~continuously~~ in Oklahoma continuously for the past five years. ~~The~~ A home is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, ~~if~~ when a registry is maintained in the applicable state, for all adult household members living in the home. ~~If no~~ When a child abuse and neglect registry is not maintained in the applicable state, a request for information is made to the applicable state; and

(vi) search of Juvenile Justice Information System (JOLTS) records for any child older than 13 years of age in the applicant's household.

(B) An application is denied ~~if~~ when the applicant or any person residing in the applicant's home:

(i) ~~or any person residing in the applicant's home~~ has a criminal conviction of or pled guilty or no contest to:

(I) physical assault, battery, or a drug-related offense ~~with~~ in the five- year period preceding the application date;

(II) child abuse or neglect;

(III) domestic abuse;

(IV) a crime against a child, including, but not limited to, child pornography;

(V) a crime involving violence, including, but not limited to, rape, sexual assault, or homicide, including manslaughter, ~~but~~ excluding physical assault and battery~~.Homicide including manslaughter~~; or

(ii) does not meet ~~the requirements of~~ OAC 340:100-3-39 requirements;

(5) ~~OKDHS~~ (DHS) Form 06AC015E, Agency Companion/Specialized Foster Care Employment Record;

(6) ~~OKDHS~~ (DHS) Form 06AC016E, ~~DDSD~~ (DDS)Reference Information Waiver;

(7) ~~OKDHS~~ (DHS) Form 06AC029E, Employer Reference Letter; and

(8) ~~OKDHS~~ (DHS) Form 06AC013E, Pre-Screening for Specialized Foster Care/Agency Companion Services.

(c) **Home profile process.** ~~If~~ When the applicant meets the requirements of the prescreening, the initial home profile process described in (1) through (8) of this subsection is initiated.

(1) The applicant completes the required forms and returns the forms to the ~~DDSD~~ DDS address provided. Required forms include ~~OKDHS~~ DHS Forms:

(A) 06AC008E, Specialized Foster Care/Agency Companion Services Application;

(B) 06AC009E, Financial Assessment;

(C) 06AC011E, Family Health History;

(D) 06AC018E, Self Study Questionnaire;

(E) 06AC019E, Child's Questionnaire;

(F) 06AC010E, Medical Examination Report, ~~if~~ when Form 06AC011E indicates conditions that may interfere with the provision of services;

(G) 06AC017E, Insurance Information; and

(H) 06AC020E, Evacuation/Escape Plan.

(2) ~~If~~ When an incomplete form or other information is returned to ~~DDSD~~ DDS, designated ~~DDSD~~ DDS staff sends a letter to the provider or provider agency identifying information needed to complete the required forms. The home profile is not completed until all required information is provided to ~~DDSD~~ DDS.

(3) Designated ~~DDSD~~ DDS staff completes the home profile when all required forms are completed and provided to ~~DDSD~~ DDS.

(4) For each reference provided by the applicant, designated ~~DDSD~~ DDS staff completes ~~OKDHS~~ DHS Form 06AC058E, Reference Letter;

(5) Designated ~~DDSD~~ DDS staff, through interviews, visits, and phone calls, gathers information required to complete ~~OKDHS~~ DHS Form 06AC047E, Home Profile Notes.

(6) ~~OKDHS~~ DHS Form 06AC069E, Review of Policies and Areas of Responsibilities, is dated and signed by the applicant and designated ~~DDSD~~ DDS staff.

(7) The ~~DDSD~~ DDS area residential services programs manager sends to the applicant:

(A) a provider approval letter confirming the applicant is approved to serve as a provider; or

(B) a denial letter stating the application ~~is~~ and home profile are denied.

(8) ~~DDSD~~ DDS staff records the dates of completion of each part of the home profile process.

(d) **Home standards.** In order to qualify and remain in compliance, the applicant's or provider's home must meet the provisions in (1) through (11) of this subsection.

(1) **General conditions.**

(A) The home, buildings, and furnishings must be comfortable, clean, and in good repair and the grounds must be maintained. There must be no accumulation of garbage, debris, or rubbish or offensive odors.

(B) The home must:

(i) be accessible to school, employment, church, day programming, recreational activities, health facilities, and other community resources as needed;

(ii) have adequate heating, cooling and plumbing; and

(iii) provide space for the member's personal possessions and privacy; ~~and allow adequate space for the recreational and socialization needs of the occupants.~~

(iv) allow adequate space for the recreational and social needs of the occupants.

(C) Provisions for the member's safety must be present, as needed, including:

(i) guards and rails on stairways;

(ii) wheelchair ramps;

(iii) widened doorways;

(iv) grab bars;

(v) adequate lighting;

(vi) anti-scald devices; and

(vii) heat and air conditioning equipment guarded and installed in accordance with manufacturer requirements. Home modifications and equipment may be provided through HCBS Waivers operated by ~~DDSD~~ DDS.

(D) Providers must not permit members to access or use swimming or other pools, hot tubs, saunas, ponds, or spas on the premises without supervision. Swimming pools, hot tubs, saunas, ponds, or spas must be equipped with sufficient safety barriers or devices designed to prevent accidental injury or unsupervised access.

(E) The household must be covered by homeowner's or renter's insurance including personal liability insurance.

(2) **Sanitation.**

(A) Sanitary facilities must be adequate and safe, including toilet and bathing facilities, water supply, and garbage and sewer disposal.

(B) ~~If~~ When a septic tank or other non-municipal sewage disposal system is used, it must be in good working order.

(C) Garbage and refuse must be stored in readily cleanable containers, pending weekly removal.

(D) Sanitation for household pets and other domestic animals must be adequate to prevent health hazards.

(i) Proof of rabies or other vaccinations as required by a licensed veterinarian for household pets must be maintained on the premises ~~for household pets~~.

(ii) Pets not confined in enclosures must be under control and not present a danger to members or guests.

(E) There must be adequate control of insects and rodents, including screens used for ventilation in good repair on doors and windows ~~used for ventilation~~.

(F) Universal precautions for infection control must be followed in care to the member. Hands and other skin surfaces must be washed immediately and thoroughly ~~if~~ when contaminated with blood or other body fluids.

(G) Laundry equipment, if in the home, must be located in a safe, well-ventilated, and clean area, with the dryer vented to the outside.

(3) **Bathrooms.** A bathroom must:

(A) provide for individual privacy and have a finished interior;

(B) be clean and free of objectionable odors; and

(C) have a bathtub or shower, flush toilet, and sink in good repair, and hot and cold water in sufficient supply to meet the member's hygiene needs.

(i) A sink must be located near each toilet.

(ii) A toilet and sink must be provided on each floor where rooms of members who are non-ambulatory or with limited mobility are located.

(iii) There must be at least one toilet, one sink, and one bathtub or shower for every six household occupants, including the provider and family.

(4) **Bedrooms.** A bedroom must:

(A) have been constructed as such when the home was built or remodeled under permit;

(B) be provided for each member.

~~(i) Minor members must not share bedrooms with adults in the household.~~

~~(ii) No more than two members may share a bedroom.~~ (i)Exception to allow members to share a bedroom may be made by DDS area residential program manager, when DDS determines sharing a bedroom is in the best interest of the member. Minor members must not share bedrooms with adults.

~~(iii) Exceptions to allow members to share a bedroom may be made by the DDSD area residential programs manager, when DDSD determines sharing a bedroom is in the best interest of the members;~~ (ii) A member must not share a bedroom with more than one other person;

(C) have a minimum of 80 square feet of usable floor space for each member or 120 square feet for two members and two means of ~~exit~~ egress. The provider, family members, or other occupants of the home must not sleep in areas designated as common use living areas, nor share bedrooms with members;

(D) be finished with walls or partitions of standard construction that go from floor to ceiling;

(E) be adequately ventilated, heated, cooled, and lighted;

(F) include an individual bed for each member consisting of a frame, box spring, and mattress at least 36 inches wide, unless a specialized bed is required to meet identified needs. Cots, rollaways, couches, futons, and folding beds must not be used for members.

(i) Each bed must have clean bedding in good condition consisting of a mattress pad, bedspread, two sheets, pillow, pillowcase, and blankets adequate for the weather.
(ii) Sheets and pillowcases must be laundered at least weekly or more often if necessary.
(iii) Waterproof mattress covers must be used for members who are incontinent;

(G) have sufficient space for each member's clothing and personal effects, including hygiene and grooming supplies.

(i) Members must be allowed to keep and use reasonable amounts of personal belongings and have private, secure storage space.
(ii) The provider assists the member in furnishing and decorating the member's bedroom.
(iii) Window coverings must be in good condition and allow privacy for members;

(H) be on ground level for members with impaired mobility or who are non-ambulatory; and

(I) be in close enough proximity to the provider to alert the provider to nighttime needs or emergencies, or be equipped with a call bell or intercom.

(5) **Food.**

(A) Adequate storage must be available to maintain food at the proper temperature, including a properly working refrigerator. Food storage must be such that food is protected from dirt and contamination and maintained at proper temperatures to prevent spoilage.

(B) Utensils, dishes, glassware, and food supplies must not be stored in bedrooms, bathrooms, or living areas.

(C) Utensils, dishes, and glassware must be washed and stored to prevent contamination.

(D) Food storage and preparation areas and equipment must be clean, free of offensive odors, and in good repair.

(6) **Phone.**

(A) A working phone must be provided in the home that is available and accessible for the member's use for incoming and outgoing calls.

(B) Phone numbers to the home and providers must be kept current and provided to ~~DDSD~~ DDS and, ~~if~~ when applicable, the provider agency.

(7) **Safety.**

(A) Buildings must meet all applicable state building, mechanical, and housing codes.

(B) Heating, in accordance with manufacturer's specifications, and electrical equipment, including wood

stoves, must be installed in accordance with all applicable fire and life safety codes. Such equipment must be used and maintained properly and in good repair.

(i) Protective glass screens or metal mesh curtains attached at top and bottom are required on fireplaces.

(ii) Unvented portable oil, gas, or kerosene heaters are prohibited.

(C) Extension cord wiring must not be used in place of permanent wiring.

(D) Hardware for all exit and interior doors must have an obvious method of operation that cannot be locked against ~~exit~~ egress.

(8) **Emergencies.**

(A) Working smoke detectors must be provided in each bedroom, adjacent hallways, and in two story homes at the top of each stairway. Alarms must be equipped with a device that warns of low battery condition, when battery operated.

(B) At least one working fire extinguisher must be in a readily accessible location.

(C) A working flashlight must be available for emergency lighting on each floor of the home.

(D) The provider:

(i) maintains a working carbon monoxide detector in the home;

(ii) maintains a written evacuation plan for the home and conducts training for evacuation with the member;

(iii) conducts fire drills quarterly and severe weather drills twice per year ~~and maintains and makes available fire drill and severe weather drill documentation for review by DDSD~~;

(iv) ~~has a written back-up plan for temporary housing in the event of an emergency; and~~ makes fire and severe weather drill documentation available for review by DDS;

(v) ~~is responsible to re-establish a residence, if the home becomes uninhabitable.~~ has a written back-up plan for temporary housing in the event of an emergency; and

(vi) is responsible to re-establish a residence, if the home becomes uninhabitable.

(E) A first aid kit must be available in the home.

(F) The address of the home must be clearly visible from the street.

(9) **Special hazards.**

(A) Firearms and other dangerous weapons must be stored in a locked permanent enclosure. Ammunition must be

stored in a separate locked location. Providers are prohibited from assisting members to obtain, possess, or use dangerous or deadly weapons per OAC 340:100-5-22.1.

(B) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers.

(C) Cleaning supplies, medical sharps containers, poisons, and insecticides must be properly stored in original, properly labeled containers in a safe area away from food, food preparation areas, dining areas, and medications.

(D) Illegal substances are not permitted on the premises.

(10) **Vehicles.**

(A) All vehicles used to transport members must meet local and state requirements for licensing, inspection, insurance, and capacity.

(B) Drivers of vehicles must have valid and appropriate driver licenses.

(11) **Medication.** Medication for the member is stored per OAC 340:100-5-32.

(e) **Evaluating the applicant and home.** The initial home profile evaluation includes, but is not limited to:

(1) evaluating the applicant's:

(A) interest and motivation;

(B) life skills;

(C) children ~~in the home~~;

(D) methods of behavior support and discipline;

(E) marital status, ~~and~~ background, and household composition~~, and children~~;

(F) income and money management; and

(G) teamwork and supervision, back-up plan, and use of relief; and

(2) assessment and recommendation. ~~DDSD~~ DDS staff:

(A) evaluates the ability of the applicant to provide services ;

(B) ~~approves only applicants who can fulfill the expectations of the role of service provider;~~
assesses the overall compatibility of the applicant and the service recipient, ensuring the lifestyles and personalities of each are compatible for the shared living arrangement. The applicant must:

(i) express a long term commitment to the service member unless the applicant will only be providing respite services;

(ii) demonstrate the skills to meet the individual needs of the member;

(iii) express an understanding of the commitment required as a provider of services;
(iv) express an understanding of the impact the arrangement will have on personal and family life;
(v) demonstrates the ability to establish and maintain positive relationships, especially during stressful situations; and

(C) ~~if the applicant does not meet standards per OAC 317:40-5-40, ensures the final recommendation includes:~~
~~(i) basis for the denial decision; and~~
~~(ii) effective date for determining the applicant as not meeting standards. Reasons for denying a profile may include, but are not limited to:~~
~~(I) lack of stable, adequate income to meet the applicant's own or total family needs or poor management of available income;~~
~~(II) a physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;~~
~~(III) the age, health, or any other condition of the applicant that impedes the applicant's ability to provide appropriate care for a member;~~
~~(IV) relationships in the applicant's household are unstable and unsatisfactory;~~
~~(V) the mental health of the applicant or other family or household member impedes the applicant's ability to provide appropriate care for a member;~~
~~(VI) references are guarded or have reservations in recommending the applicant;~~
~~(VII) the applicant fails to complete the application, required training, or verifications in a timely manner as requested or provides information that is incomplete, inconsistent, or untruthful; or~~
~~(VIII) the home is determined unsuitable for the member requiring placement;~~
approves only applicants who can fulfill the expectations of the role of service provider;

(D) ~~notifies the applicant in writing of the final recommendation; and~~ when the applicant does not meet standards per OAC 317:40-5-40, ensures the final recommendation includes:
(i) a basis for the denial decision; and
(ii) an effective date for determining the applicant does not meet standards. Reasons for denying a request to be a provider may include, but are not limited to:

(I) a lack of stable, adequate income to meet the applicant's own or total family needs or poor management of the available income;
(II) a physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;
(III) the age, health, or any other condition of the applicant that impedes the applicant's ability to provide appropriate care for a member;
(IV) relationships in the applicant's household that are unstable and unsatisfactory;
(V) the mental health of the applicant or other family or household member that impedes the applicant's ability to provide appropriate care for a member;
(VI) references who are guarded or have reservations in recommending the applicant;
(VII) the reason the applicant failed to complete the application, required training, or verifications in a timely manner as requested or provided incomplete, inconsistent, or untruthful information;
(VIII) the home is determined unsuitable for the member requiring placement;
(IX) confirmed abuse, neglect, or exploitation of any person;
(X) breach of confidentially;
(XI) involvement of the applicant or provider involvement in criminal activity or criminal activity in the home;
(XII) failure to complete training per OAC 340:100-3-38;
(XIII) failure of the home to meet standards per subsection (d) of this Section;
(XIV) failure to follow applicable DHS or Oklahoma Health Care Authority (OHCA)rules;

(E) ~~if an application is canceled or withdrawn prior to completion of the profile, completes a final written assessment that includes:~~
~~(i) reason the application was canceled or withdrawn;~~
~~(ii) DDSD staff's impression of the applicant based on information obtained; and~~
~~(iii) effective date of cancellation or withdrawal. Written notice is sent to the applicant to confirm cancellation or withdrawal of the application, a copy is included in local and State Office records.~~

notifies the applicant in writing of the final approval or denial of the home profile;

(F) when an application is canceled or withdrawn prior to completion of the home profile, completes a final written assessment that includes the:

(i) reason the application was canceled or withdrawn; and

(ii) DDS staff's impression of the applicant based on information obtained; and

(iii) effective date of cancellation or withdrawal. Written notice is sent to the applicant to confirm cancellation or withdrawal of the application, and a copy is included in local and State Office records.

(f) **Frequency of evaluation.** ~~Homes are assessed for~~ Home profile evaluations are completed for initial approval or denial of an applicant. After an initial approval, a home profile review is conducted annually and as needed for compliance and continued approval. ~~Agency Companion Services providers are assessed annually and as needed for compliance and continued approval. Specialized foster care and respite homes are assessed bi-annually and as needed for compliance and continued approval. Any other situations requiring a home profile are assessed annually and as needed for compliance and continued approval.~~ DDS area residential services staff conduct at least biannual home visits to specialized foster care providers. The annual ~~evaluation~~ home profile review is a comprehensive review of the living arrangement, the provider's continued ability to meet standards~~.~~, the needs of the member and the home to ensure ongoing compliance with home standards. A home profile review is conducted when a provider notifies DDS of his or her intent to move to a new residence. DDS staff asses the home to ensure the new home meets home standards and is suitable to meet the member's needs. The annual home profile review;

(1) ~~The annual evaluation consists of~~ includes information specifically related to the provider's home and is documented on ~~OKDHS~~ DHS Form 06AC024E, Annual Review~~.~~;

(2) ~~OKDHS~~ include ~~FORM~~ form 06AC010E,Medical Examination Report, ~~must~~ ~~be~~ completed a minimum of every three years following the initial approval, unless medical circumstances warrant more frequent completion~~.~~;

(3) ~~Input~~ includes information from the ~~DDSD~~ DDS case manager, the provider of agency companion or SFC services, the Child Welfare ~~worker~~ specialist, Adult Protective Services ~~staff~~, and Office of Client Advocacy staff, and the provider agency program coordinator ~~is included in the evaluation, if~~ when applicable.

(4) ~~The background investigation per OAC 317:40-5-40(b) is repeated every year, except the FBI national criminal history search.~~ includes information from the service member indicating satisfaction with service and a desire to continue the arrangement;

(5) ~~Providers are notified in writing of the continued recommendation of the use of the home.~~ addresses areas of service where improvement is needed;

(6) ~~Copies of OKDHS Forms 06AC024E and, if applicable, 06AC010E, are included in local and State Office records.~~ includes areas of service where progress was noted or were of significant benefit to the member;

(7) ensures background investigation per OAC 317:40-5-40(b) is repeated every year, except for the OSBI and FBI national criminal history search;

(8) ensures the FBI national criminal history search per OAC 317:40-5-40(b)(4)(A)(ii) is repeated every five years;

(9) includes written notification to providers and agencies, when applicable, of the continued approval of the provider.

(10) includes written notification to providers and agencies, when the provider or agency fails to comply with the home standards per OAC 317:40-5-40 including deadlines for correction of the identified standards; and includes copies of DHS Forms 06AC024E and, when applicable, 06AC010E, in local and State Office records.

(g) Reasons a home profile review may be denied include, but are not limited to:

(1) lack of stable, adequate income to meet the provider's own or total family needs or poor management of available income;

(2) a physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;

(3) the age, health, or any other condition of the provider that impedes the provider's ability to provide appropriate care for a member;

(4) relationship in the provider's household that are unstable and unsatisfactory;

(5)the mental health of the provider or other family or household member impedes the provider's ability to provide appropriate care for a member;

(6) the provider fails to complete required training, or verifications in a timely manner as requested or provides incomplete, inconsistent, or untruthful information;

(7) the home is determined unsuitable for the member;

(8) failure of the provider to complete task related to problem resolution, as agreed, per OAC 340:100-3-27;

(9) failure of the provider to complete a plan of action, as agreed, per OAC 317:40-5-63;
(10) confirmed abuse, neglect, or exploitation of any person;
(11) breach of confidentiality;
(12) involvement of the provider in criminal activity in the home;
(13) failure to provide for the care and well-being of the service member;
(14) failure or continued failure to implement the individual Plan, per OAC 340:100-5-50 through 100-5-58;
(15) failure to complete and maintain training per OAC 340:100-3-38.1;
(16) failure to report changes in the household;
(17) failure to meet standards of the home per subsection (d) of this Section;
(18) failure or continued failure to follow applicable DHS or OHCA rules;
(19) decline of the provider's health to the point he or she can no longer meet the needs of the service member;
(20) employment by the provider without prior approval of the DDS area programs manager for residential services; or
(21) domestic disputes that causes emotional distress to the member.

Recommendation 1: Prior Authorize Sivextro™ (Tedizolid), Dalvance™ (Dalbavancin), and Orbactiv™ (Oritavancin)

The Drug Utilization Review Board recommends the prior authorization of Sivextro™, Dalvance™, and Orbactiv™ with the following criteria:

Sivextro™ (Tedizolid Phosphate) Tablet Approval Criteria:

1. An indicated diagnosis or infection known to be susceptible to requested agent and resistant to the cephalosporin-class of antibiotics and other antibiotics commonly used for diagnosis or infection; and
2. A patient-specific, clinically significant reason why the member cannot use Zyvox® (linezolid) or other cost effective therapeutic equivalent medication(s).
3. A quantity limit of six tablets per six days will apply.

Dalvance™ (Dalbavancin) Approval Criteria:

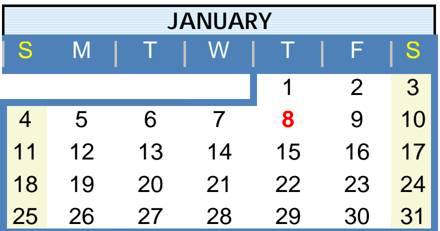
1. An indicated diagnosis or infection known to be susceptible to requested agent and resistant to the cephalosporin-class of antibiotics and other antibiotics commonly used for diagnosis or infection; and
2. A patient-specific, clinically significant reason why the member cannot use vancomycin, Zyvox® (linezolid) or other cost effective therapeutic equivalent medication(s).
3. A quantity limit of two vials per seven days will apply.

Orbactiv™ (Oritavancin) Approval Criteria:

1. An indicated diagnosis or infection known to be susceptible to requested agent and resistant to the cephalosporin-class of antibiotics and other antibiotics commonly used for diagnosis or infection; and
2. A patient-specific, clinically significant reason why the member cannot use vancomycin, Zyvox® (linezolid) or other cost effective therapeutic equivalent medication(s).
3. A quantity limit of three vials per 30 days will apply.

Medication	Regimen	Cost of Therapy
Sivextro™ 200mg Tablets	200mg once daily for 6 days	$1,869.12
Sivextro™ 200mg Vial	200mg once daily for 6 days	$1,488.96
Dalvance™ 500mg Vial	1000mg Day 1 then 500mg Day 8	$4,720.32
Orbactiv™ 400mg Vial	1200mg Day 1	$3,062.40
Zyvox® 600mg Tablets[∞]	600 mg every 12 hours for 10 days[*]	$2,863.40
Zyvox® 600mg/300mL IV Soln	600 mg every 12 hours for 10 days[*]	$2,700.00
Vancomycin 500mg Vial	1000mg every 12 hours for 7-10 days	$84-$120

PROPOSED OHCA BOARD MEETINGS/LOCATIONS - 2015



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January 8, 2015 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

February 12, 2015 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

March 26, 2015 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

May 14, 2015 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

June 25, 2015 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

August 12, 2015 • Board Meeting • 1:00 pm
August 12, 2015 • SPC • 2:30 pm
August SPC • 13 & 14, 2015 • 8:30 am
TBD

September 10, 2015 • 1:00 pm
Lawton
Location TBD

October 8, 2015 • 1:00 pm
Duncan
Location TBD

November 12, 2015 • 1:00 pm
Enid
Location TBD

December 10, 2015 • 1:00 pm
Tulsa
Location TBD

JULY						
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*Dates in Red are Proposed Board Dates