OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
December 10, 2015 at 1:00 P.M.
Oklahoma Health Care Authority
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 Approval of November 12, 2015 OHCA Board Meeting Minutes

Item to be presented by Nico Gomez, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) All-Star Introduction

      - July 2015 All-Star – Sheryl Houck, Purchasing Assistant (Carrie Evans)
      - August 2015 All-Star – Jean Krieske, Medical Administrative Nurse (Sylvia Lopez)
      - October 2015 All-Star – Darla Koone, QA/QI SoonerCare Compliance Analyst (Sylvia Lopez)

   b) Financial Update – Carrie Evans, Chief Financial Officer

   c) Medicaid Director's Update – Garth Splinter, State Medicaid Director

Item to be presented by Andrew Cohen, Pacific Health Policy Group

4. Discussion Item – ABD Care Coordination Update

Item to be presented by Dana Miller, Tribal Governmental Relations Director

5. Discussion Item – 8th Annual Tribal Consultation Meeting and SFY 2015 Tribal Governmental Relations Report

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

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

Item to be presented by Carrie Evans, Chairperson of the State Plan Amendment Rate Committee

7. Action Item – Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate Committee.

   a) Consideration and vote to implement a rate reduction in the amount of 3.00% to providers reimbursed on the Medicaid physician fee schedule and other payment methodologies. These changes have an estimated total dollar savings of $25,917,478, of which $8,343,579 is state

savings in SFY2016. In SFY2017 these changes have an estimated total dollar savings of $50,770,065, of which $20,206,485 is state savings.

b) Consideration and vote to implement a rate reduction in the amount of 3.00% to providers reimbursed for services under the Medically Fragile Waiver. This change has an estimated total dollar savings of $21,335, of which $8,323 is state savings in SFY2016. In SFY2017, this change has an estimated total dollar savings of $128,009, of which $50,947 is state savings.

c) Consideration and Vote to reduce the reimbursement for deductibles and co-insurance for nursing facility Part A Medicare Crossover claims to 20%. This change has an estimated total dollar savings of $6,130,523, of which $2,391,517 is state savings in SFY2016. In SFY2017, this change has an estimated total dollar savings of $12,017,673, of which $4,783,034 is state savings.

d) Consideration and Vote to add two new codes (G0299 and G0300) for Direct Skilled Nursing Services provided under the Medically Fragile Waiver. This change has no budget impact.

e) Consideration and Vote to add two new codes (G0299 and G0300) for Direct Skilled Nursing Services provided under the ADvantage Waiver. This change has no budget impact.

f) Consideration and Vote to add two new codes (G0299 and G0300) for Direct Skilled Nursing Services provided under Developmental Disabilities Services. This change has no budget impact.

g) Consideration and Vote to add two new codes (81420 and 81507) for Non-Invasive Prenatal Testing (NIPT) for women with high-risk pregnancies. This change has an estimated total dollar cost of $953,530, of which $371,972 is state savings.

h) Consideration and Vote to add two new codes (99444 and 98969) for online telemedicine visits to be performed by a Physician, Physician Assistant, or Advanced Registered Nurse Practitioner. This change has no budget impact, with the potential for long-term savings.

Item to be presented by Tywanda Cox, Chief of Federal and State Policy

8. a) Action Item – Consideration and Vote upon declaration of a Compelling Public Interest for the promulgation of **all Emergency Rules** in action item eight of this agenda in accordance with 75 Okla. Stat. § 253.

b) 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.

A. AMENDING Agency rules at OAC 317:35-17-5 and 317:30-5-763 to comply with federal regulation. The proposed changes adhere to the CMS conflict free case management requirements and changes adhere to Home and Community Based settings requirements for Medicaid Assisted Living Programs that are directly related to the Assisted Living Service Option in ADvantage program. There is no anticipated budget impact to comply with the federal regulation.
Budget Impact: Budget neutral

(Reference APA WF # 15-14A&B)

Item to be presented by Vickie Kersey, Director of Fiscal Planning and Procurement

9. Action Item – Consideration and Vote of Authority for Expenditure of Funds for Insure Oklahoma Multimedia Marketing Staplegun Design, Inc.

Item to be presented by Ed McFall, Chairman

10. Action Item – Consideration and Vote upon the Oklahoma Health Care Authority Board Meeting Dates, Times and Locations for Calendar Year 2016

11. Action Item – Election of the Oklahoma Health Care Authority 2015-2016 Board Officers

12. New Business

13. ADJOURNMENT

NEXT BOARD MEETING
January 14, 2016
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 12, 2015
Held at the Non-Profit Center
Enid, Oklahoma

DRAFT

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 10, 2015 at 10:30 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 6, 2015 at 3:30 p.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 1:03 p.m.

<u>BOARD MEMBERS PRESENT:</u> Chairman McFall, Vice-Chairman McFall, Member Nuttle, Member McVay, Member Case, Member Bryant

<u>BOARD MEMBERS ABSENT:</u> Member Robison

<u>OTHERS PRESENT:</u>
LeKenya Antwine, OHCA
Sylvia Lopez, OHCA
Taylor Randolph, Youth & Family Services
Jean Ann Ingram, SOFS
Will Widman, HPE
OAHCP
Mike Fogarty

<u>OTHERS PRESENT:</u>
Tywanda Cox, OHCA
Garth Splinter, OHCA
Virginia Ragan, SOFS
Ross Vanhouser, MD, Citizen
Charles Brodt, HPE
Terry McCurren, American

<u>DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD OCTOBER 8, 2015.</u>

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.

<u>MOTION:</u> Member Case moved for approval of the October 8, 2015 board meeting minutes as published. The motion was seconded by Member McVay.

<u>FOR THE MOTION:</u> Chairman McFall, Member Case, Member McVay

<u>ABSTAINED:</u> Vice-Chairman Armstrong, Member Bryant, Member Nuttle

<u>ABSENT:</u> Member Robison

<u>NICO GOMEZ, CHIEF EXECUTIVE OFFICER'S REPORT</u>

Mr. Gomez thanked Member Bryant and the Non-Profit Center for hosting the board meeting in Enid, Oklahoma.

<u>ITEM 3a / FINANCIAL UPDATE</u>
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the final financial transactions through the month of September. The OHCA finished the month with $8.4 million state dollars positive variance and finished under budget in program spending by $7.7 million state dollars and $0.8 million state dollars in administration. Ms. Evans reported that we are under budget in drug rebate and overpayments and settlements but anticipates as the year goes on, those numbers should swing the other direction. She predicted that OHCA will continue to be slightly under budget for October. For more detailed information, see Item 3a in the board packet.

<u>ITEM 3b / MEDICAID DIRECTOR'S UPDATE</u>
Garth Splinter, State Medicaid Director

Dr. Splinter provided an update for September data that included a report on the number of enrollees in different areas of the Medicaid program. He discussed the charts provided for dual enrollees and long-term care members as well as children and adult enrollment. Dr. Lopez discussed HEDIS quality measures for comprehensive diabetes care, hemoglobin A1C testing, medical attention for nephropathy and retinal eye exam. For more detailed information, see Item 3b in the board packet.

ITEM 3c / PROPOSED OHCA 2016 BOARD MEETING DATES AND LOCATIONS
Nico Gomez, CEO

Mr. Gomez proposed the next calendar year's board meeting dates and locations. He said that we will bring the dates back to the board in December for consideration. For more detailed information, see Item 3c in the board packet.

ITEM 3d / BUDGET UPDATE
Nico Gomez, CEO

Mr. Gomez discussed that the OHCA will bring a budget change to the board for the December board meeting and that we have been talking about it for several months now. OHCA has reviewed all perimeters of the program to determine the amount of funding needed for the program July 1 in light of the loss in federal matching. The agency has determined we need about $37.5 million dollars more than what we received this year in our base appropriation. The legislature and the Governor's office advised us to bring a flat budget and in order to balance the $37.5 million dollars, he will propose to the board in December a 3% across the board provider rate cut effective January 1, 2016. The agency will have a rates and standards committee meeting December 9th that we will take that $37.5 million and spread it over 17 or 18 months to where we have a flat budget for July 1. He heard State revenues are coming in a lot lower than projected which can certainly have an impact on us. If the board considers the provider rate cut, and we do have a revenue failure, it could consume some of that savings. Mr. Gomez said that this does not mean that we will not have cuts later. The legislature still does not know how much money they will have to appropriate and until we know that number, there is a chance that we may bring the board members another cut this summer, which he hopes is not the case.

Member Case asked Mr. Gomez to explain why we need $37.5 million dollars more in 2016. Mr. Gomez discussed Federal Medical Assistance Percentage (FMAP), which is a federal formula based on a 3 year rolling average of a state's per capita income which produces a match rate for states. Every state gets at least 50% federal matching dollars based upon their federal matching formula. Our match rate has gone down because the state's per capita income has been one of the strongest in the nation, so comparatively, the formula says that we will not receive as much federal funds and doesn't account for the number of people that we serve and number of people in poverty.

Mr. Gomez said that the Governor had an executive order regarding a 10% administrative cut and he is still trying to understand what that means. The executive order also froze travel and requires OHCA to do certain requests for expenditures above $10,000. He stated that we have to submit a plan by December 1st and will update the board at the December board meeting.

ITEM 3e / ABD CARE COORDINATION UPDATE
Nico Gomez, CEO

Mr. Gomez stated that we continue to meet with stakeholders on the ABD care coordination as mandated by the HB1566 that directs the agency to initiate a request for proposal (RFP) for care coordination models for our ABD population. We had a stakeholder meeting recently that continue to go well with a lot of information and is a very transparent and open process. OHCA will make an announcement on what model or models will be pursued in the RFP on November 30th and will come through an email to all stakeholders who provided their contact information. There will also be a press release and an update to our website. The December and January monthly stakeholder meetings will be put on hiatus as we will be in a period of silence to avoid any potential conflicts with the procurement process and will resume meetings in February. If we stay on schedule, we expect a draft RFP submitted to our federal partner, CMS, in March which would also be out for public review. We hope to release a bid for solicitation in June.

ITEM 4 / COMMUNITY PARTNERSHIPS PRESENTATION
Melinda Snowden, Health Promotion Strategist

Ms. Snowden stated that she works in 20 counties in northwest Oklahoma. Ms. Snowden presented on community engagement and community forums that are held annually. She discussed partnerships with Pioneer Telephone

DRAFT

Cooperative, Oklahoma Family Network and Garfield County Micronesian Coalition. She talked about the successes and next steps for the Texas county access to care project. For more detailed information, see Item 4 in the board packet.

ITEM 5 / PHARMACY BENEFIT OVERVIEW
Nancy Nesser, Pharmacy Director

Dr. Nesser presented a pharmacy benefit overview that consisted of explaining the pharmacy department FTE positions, our contractor OU College of Pharmacy and Pharmacy Management Consultants (PMC). Dr. Nesser discussed services performed by PMC, pharmacy program stats for SFY 15, SoonerCare pharmacy program background, federal Medicaid pharmacy policy, pharmacy benefits and SoonerCare pharmacy policy. She also discussed prior authorization types, DUR Board prior authorization process, federal drug rebate program, PMC benefit analysis and program results. For more detailed information, see Item 5 in the board packet.

ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 7 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES §5030.3.
Nancy Nesser, Pharmacy Director

a) Consideration and vote to add **Tykerb® (Lapatinib), Halaven® (Eribulin), Ixempra® (Ixabepilone), Kadcyla® (Ado-Trastuzumab), Afinitor® (Everolimus), & Perjeta® (Pertuzumab)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Consideration and vote to add **Orkambi™ (Lumacaftor/Ivacaftor)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Consideration and vote to add **Savaysa® (Edoxaban)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) Consideration and vote to add **Epanova® (Omega-3-Carboxylic Acids), Praluent® (Alirocumab), & Repatha™ (Evolocumab)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member Nuttle moved for approval of Item 7a-d as published. The motion was seconded by Vice-Chairman Armstrong.

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

ABSENT: Member Robison

ITEM 8 / 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: Vice-Chairman Armstrong moved for approval to go into Executive Session. The motion was seconded by Member Nuttle.

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

ABSENT: Member Robison

8. Discussion Item – 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).

DRAFT

a) CEO Evaluation

ITEM 9 / NEW BUSINESS

There was no new business.

ITEM 10 / BOARD MEMBER FACILITY TOUR

Due to time, the board members did not participate in a tour.

ITEM 11 / ADJOURNMENT

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

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

ABSENT: Member Robison

Meeting adjourned at 3:25 p.m., 11/12/2015

NEXT BOARD MEETING
December 10, 2015
Oklahoma Health Care Authority
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _______________

*Initials:*______________

DRAFT

FINANCIAL REPORT

For the Four Months Ended October 31, 2015
Submitted to the CEO & Board

- Revenues for OHCA through October, accounting for receivables, were **$1,421,221,789** or **1.9% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,374,247,934 or 2.8% under** budget.
- The state dollar budget variance through October is a **positive $11,321,853.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	10.4
Administration	1.2
Revenues:	
Drug Rebate	(0.1)
Taxes and Fees	1.6
Overpayments/Settlements	(1.8)
Total FY 15 Variance	**$ 11.3**

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
SFY 2016, For the Four Month Period Ending October 31, 2015

REVENUES	FY16 Budget YTD	FY16 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 322,035,136	$ 322,035,136	$ -	0.0%
Federal Funds	825,214,055	800,622,576	(24,591,480)	(3.0)%
Tobacco Tax Collections	15,420,054	16,974,650	1,554,596	10.1%
Quality of Care Collections	25,686,230	25,355,445	(330,785)	(1.3)%
Prior Year Carryover	67,016,727	67,016,727	-	0.0%
Federal Deferral - Interest	101,972	101,972	-	0.0%
Drug Rebates	73,932,044	73,636,563	(295,481)	(0.4)%
Medical Refunds	15,880,849	11,132,408	(4,748,441)	(29.9)%
Supplemental Hospital Offset Payment Program	99,717,458	99,717,458	-	0.0%
Other Revenues	4,256,046	4,628,855	372,809	8.8%
TOTAL REVENUES	**$ 1,449,260,571**	**$ 1,421,221,789**	**$ (28,038,783)**	**(1.9)%**

EXPENDITURES	FY16 Budget YTD	FY16 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 17,845,122**	**$ 16,986,766**	**$ 858,356**	**4.8%**
ADMINISTRATION - CONTRACTS	**$ 30,903,535**	**$ 29,160,892**	**$ 1,742,643**	**5.6%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	14,488,458	13,425,303	1,063,156	7.3%
Acute Fee for Service Payments:				
Hospital Services	311,203,435	301,320,799	9,882,637	3.2%
Behavioral Health	6,706,122	6,623,174	82,949	1.2%
Physicians	169,953,141	157,467,069	12,486,073	7.3%
Dentists	44,413,512	45,976,135	(1,562,623)	(3.5)%
Other Practitioners	11,661,274	15,416,872	(3,755,599)	(32.2)%
Home Health Care	6,859,994	6,798,598	61,396	0.9%
Lab & Radiology	25,916,009	21,466,471	4,449,538	17.2%
Medical Supplies	15,234,622	15,004,710	229,912	1.5%
Ambulatory/Clinics	45,837,971	41,622,352	4,215,619	9.2%
Prescription Drugs	174,548,942	170,198,911	4,350,031	2.5%
OHCA Therapeutic Foster Care	547,601	333,777	213,824	39.0%
Other Payments:				
Nursing Facilities	193,208,657	192,154,624	1,054,034	0.5%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	20,865,499	20,733,153	132,346	0.6%
Medicare Buy-In	44,428,699	46,297,700	(1,869,001)	(4.2)%
Transportation	24,532,886	22,216,320	2,316,567	9.4%
Money Follows the Person-OHCA	238,292	177,226	61,066	0.0%
Electonic Health Records-Incentive Payments	3,505,987	3,505,987	-	0.0%
Part D Phase-In Contribution	26,449,573	26,436,777	12,796	0.0%
Supplemental Hospital Offset Payment Program	220,924,319	220,924,319	-	0.0%
Telligen	3,325,760	-	3,325,760	100.0%
Total OHCA Medical Programs	**1,364,850,754**	**1,328,100,276**	**36,750,478**	**2.7%**
OHCA Non-Title XIX Medical Payments	9,158	-	9,158	0.0%
TOTAL OHCA	**$ 1,413,608,569**	**$ 1,374,247,934**	**$ 39,360,635**	**2.8%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 35,652,002**	**$ 46,973,855**	**$ 11,321,853**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2016, For the Four Month Period Ending October 31, 2015

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 13,471,071	$ 13,421,127	$ -	$ 45,768	$ -	$ 4,176	$ -
Inpatient Acute Care	445,644,335	202,645,471	162,229	1,175,415	163,566,452	632,642	77,462,126
Outpatient Acute Care	143,488,977	96,743,472	13,868	1,331,197	44,277,323	1,123,117	
Behavioral Health - Inpatient	20,159,485	3,940,742	-	97,984	12,309,757	-	3,811,003
Behavioral Health - Psychiatrist	3,453,219	2,682,432	-	-	770,787	-	-
Behavioral Health - Outpatient	9,544,157	-	-	-	-	-	9,544,157
Behaviorial Health-Health Home	6,795,614	-	-	-	-	-	6,795,614
Behavioral Health Facility- Rehab	77,391,691	-	-	-	-	22,922	77,391,691
Behavioral Health - Case Management	6,149,980	-	-	-	-	-	6,149,980
Behavioral Health - PRTF	27,786,954	-	-	-	-	-	27,786,954
Residential Behavioral Management	7,134,699	-	-	-	-	-	7,134,699
Targeted Case Management	23,075,776	-	-	-	-	-	23,075,776
Therapeutic Foster Care	333,777	333,777	-	-	-	-	-
Physicians	178,297,021	155,544,707	19,367	904,218	-	1,902,995	19,925,734
Dentists	45,979,516	45,971,907	-	3,381	-	4,228	-
Mid Level Practitioners	879,196	874,736	-	4,325	-	134	-
Other Practitioners	14,568,559	14,391,455	148,788	26,558	-	1,759	-
Home Health Care	6,800,472	6,794,451	-	1,875	-	4,147	-
Lab & Radiology	21,944,961	21,344,891	-	478,490	-	121,580	-
Medical Supplies	15,094,474	14,088,149	903,844	89,764	-	12,718	-
Clinic Services	41,753,556	39,196,974	-	220,197	-	54,144	2,282,241
Ambulatory Surgery Centers	2,418,452	2,366,338	-	47,218	-	4,896	-
Personal Care Services	4,498,134	-	-	-	-	-	4,498,134
Nursing Facilities	192,154,624	121,142,859	71,008,652	-	-	3,113	-
Transportation	22,162,121	21,268,288	878,537	-	-	15,296	-
GME/IME/DME	58,128,570	-	-	-	-	-	58,128,570
ICF/IID Private	20,733,153	16,930,678	3,802,475	-	-	-	-
ICF/IID Public	3,353,962	-	-	-	-	-	3,353,962
CMS Payments	72,734,477	72,494,234	240,242	-	-	-	
Prescription Drugs	173,631,216	169,616,665	-	3,432,305	-	582,246	-
Miscellaneous Medical Payments	54,199	53,982	-	-	-	217	-
Home and Community Based Waiver	66,757,158	-	-	-	-	-	66,757,158
Homeward Bound Waiver	29,223,163	-	-	-	-	-	29,223,163
Money Follows the Person	2,457,808	177,226	-	-	-	-	2,280,582
In-Home Support Waiver	8,811,433	-	-	-	-	-	8,811,433
ADvantage Waiver	62,499,708	-	-	-	-	-	62,499,708
Family Planning/Family Planning Waiver	2,063,898	-	-	-	-	-	2,063,898
Premium Assistance*	14,900,278	-	-	14,900,278	-	-	-
Electronic Health Records Incentive Payments	3,505,987	3,505,987	-	-	-	-	-
Total Medicaid Expenditures	**$ 1,849,835,829**	**$ 1,025,530,549**	**$ 77,178,002**	**$ 22,758,973**	**$ 220,924,319**	**$ 4,490,328**	**$ 498,976,580**

* Includes $14,802,118 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2016, For the Four Month Period Ending October 31, 2015

		FY16
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	205,186,368
Federal Funds		309,453,093
TOTAL REVENUES	**$**	**514,639,460**

EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	66,757,158
Money Follows the Person		2,280,582
Homeward Bound Waiver		29,223,163
In-Home Support Waivers		8,811,433
ADvantage Waiver		62,499,708
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		3,353,962
Personal Care		4,498,134
Residential Behavioral Management		5,495,188
Targeted Case Management		19,197,169
Total Department of Human Services		**202,116,495**
State Employees Physician Payment		
Physician Payments		19,925,734
Total State Employees Physician Payment		**19,925,734**
Education Payments		
Graduate Medical Education		24,915,759
Graduate Medical Education - Physicians Manpower Training Commission		964,495
Indirect Medical Education		32,248,316
Direct Medical Education		-
Total Education Payments		**58,128,570**
Office of Juvenile Affairs		
Targeted Case Management		1,019,593
Residential Behavioral Management		1,639,511
Total Office of Juvenile Affairs		**2,659,104**
Department of Mental Health		
Case Management		6,149,980
Inpatient Psychiatric Free-standing		3,811,003
Outpatient		9,544,157
Health Homes		6,795,614
Psychiatric Residential Treatment Facility		27,786,954
Rehabilitation Centers		77,391,691
Total Department of Mental Health		**131,479,399**
State Department of Health		
Children's First		742,208
Sooner Start		743,918
Early Intervention		1,700,997
Early and Periodic Screening, Diagnosis, and Treatment Clinic		852,442
Family Planning		7,319
Family Planning Waiver		2,054,490
Maternity Clinic		5,924
Total Department of Health		**6,107,298**
County Health Departments		
EPSDT Clinic		217,309
Family Planning Waiver		2,088
Total County Health Departments		**219,397**
State Department of Education		**65,263**
Public Schools		**350,546**
Medicare DRG Limit		**72,250,000**
Native American Tribal Agreements		**462,649**
Department of Corrections		**423,826**
JD McCarty		**4,788,299**
Total OSA Medicaid Programs	**$**	**498,976,580**
OSA Non-Medicaid Programs	**$**	**23,216,567**
Accounts Receivable from OSA	**$**	**7,553,686**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2016, For the Four Month Period Ending October 31, 2015

REVENUES	FY 16 Revenue
SHOPP Assessment Fee	$ 99,409,311
Federal Draws	136,213,508
Interest	39,613
Penalties	268,534
State Appropriations	(15,100,000)
TOTAL REVENUES	**$ 220,830,966**

EXPENDITURES	Quarter	Quarter	FY 16 Expenditures
Program Costs:	7/1/15 - 9/30/15	10/1/15 - 12/31/15	
Hospital - Inpatient Care	83,225,354	80,341,099	$ 163,566,452
Hospital -Outpatient Care	22,465,442	21,811,881	44,277,323
Psychiatric Facilities-Inpatient	6,265,547	6,044,210	12,309,757
Rehabilitation Facilities-Inpatient	392,213	378,574	770,787
Total OHCA Program Costs	112,348,555	108,575,764	$ 220,924,319
Total Expenditures			$ 220,924,319
CASH BALANCE			$ (93,353)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2016, For the Four Month Period Ending October 31, 2015

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 25,341,459**	**$ 25,341,459**
Interest Earned	**13,986**	**13,986**
TOTAL REVENUES	**$ 25,355,445**	**$ 25,355,445**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 69,796,918	$ 26,313,438	
Eyeglasses and Dentures	92,154	34,742	
Personal Allowance Increase	1,119,580	422,082	
Coverage for Durable Medical Equipment and Supplies	903,844	340,749	
Coverage of Qualified Medicare Beneficiary	344,252	129,783	
Part D Phase-In	240,242	240,242	
ICF/IID Rate Adjustment	1,778,688	670,565	
Acute Services ICF/IID	2,023,787	762,968	
Non-emergency Transportation - Soonerride	878,537	331,208	
Total Program Costs	**$ 77,178,002**	**$ 29,245,778**	**$ 29,245,778**
Administration			
OHCA Administration Costs	$ 174,477	$ 87,238	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 174,477**	**$ 87,238**	**$ 87,238**
Total Quality of Care Fee Costs	**$ 77,352,479**	**$ 29,333,016**	
TOTAL STATE SHARE OF COSTS			**$ 29,333,016**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2016, For the Four Month Period Ending October 31, 2015

REVENUES	FY 15 Carryover	FY 16 Revenue	Total Revenue
Prior Year Balance	$ 27,746,235	$ -	$ 1,498,834
State Appropriations	(25,000,000)	-	-
Tobacco Tax Collections	-	13,961,577	13,961,577
Interest Income	-	82,576	82,576
Federal Draws	235,637	7,970,387	7,970,387
TOTAL REVENUES	**$ 2,981,872**	**$ 22,014,540**	**$ 23,513,374**

EXPENDITURES	FY 15 Expenditures	FY 16 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 14,802,118	$ 14,802,118
College Students		98,161	35,318
Individual Plan			
SoonerCare Choice		$ 43,839	$ 15,773
Inpatient Hospital		1,175,415	422,914
Outpatient Hospital		1,312,899	472,381
BH - Inpatient Services-DRG		95,738	34,446
BH -Psychiatrist		-	-
Physicians		891,822	320,878
Dentists		2,624	944
Mid Level Practitioner		4,323	1,555
Other Practitioners		26,087	9,386
Home Health		1,875	674
Lab and Radiology		471,579	169,674
Medical Supplies		85,341	30,706
Clinic Services		216,535	77,909
Ambulatory Surgery Center		47,218	16,989
Prescription Drugs		3,380,355	1,216,252
Miscellaneous Medical		-	-
Premiums Collected		-	(144,515)
Total Individual Plan		**$ 7,755,648**	**$ 2,645,967**
College Students-Service Costs		**$ 103,047**	**$ 37,076**
Total OHCA Program Costs		**$ 22,758,973**	**$ 17,520,479**
Administrative Costs			
Salaries	$ 73,467	$ 706,513	$ 779,980
Operating Costs	60,069	329,159	389,228
Health Dept-Postponing	-	-	-
Contract - HP	1,349,503	1,792,059	3,141,562
Total Administrative Costs	**$ 1,483,038**	**$ 2,827,731**	**$ 4,310,770**
Total Expenditures			**$ 21,831,249**
NET CASH BALANCE	**$ 1,498,834**		**$ 1,682,126**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2016, For the Four Month Period Ending October 31, 2015

REVENUES	FY 16 Revenue	State Share
Tobacco Tax Collections	$ 278,548	$ 278,548
TOTAL REVENUES	**$ 278,548**	**$ 278,548**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 4,176	$ 1,102	
Inpatient Hospital	632,642	166,954	
Outpatient Hospital	1,123,117	296,391	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	3,113	821	
Physicians	1,902,995	502,200	
Dentists	4,228	1,116	
Mid-level Practitioner	134	35	
Other Practitioners	1,759	464	
Home Health	4,147	1,094	
Lab & Radiology	121,580	32,085	
Medical Supplies	12,718	3,356	
Clinic Services	54,144	14,289	
Ambulatory Surgery Center	4,896	1,292	
Prescription Drugs	582,246	153,655	
Transportation	15,296	4,037	
Miscellaneous Medical	217	57	
Total OHCA Program Costs	$ 4,467,407	$ 1,178,949	
OSA DMHSAS Rehab	$ 22,922	$ 6,049	
Total Medicaid Program Costs	$ 4,490,328	$ 1,184,998	
TOTAL STATE SHARE OF COSTS			**$ 1,184,998**

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.

OHCA Board Meeting
December 10, 2015
(October 2015 Data)

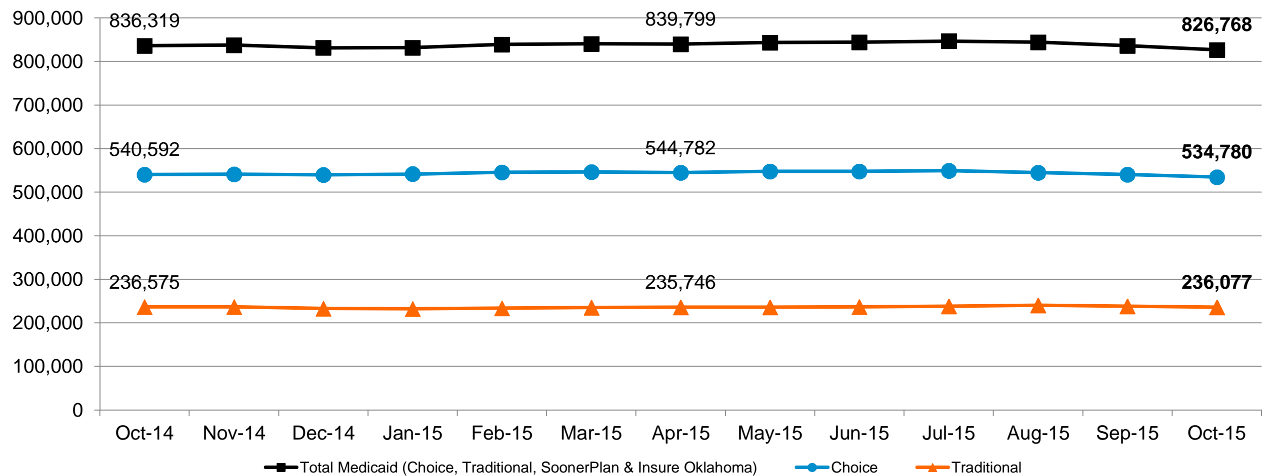
SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Enrollment October 2015	Children October 2015	Adults October 2015	Enrollment Change	Total Expenditures October 2015	PMPM October 2015	Forecasted October 2015 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home		**534,780**	**439,703**	**95,077**	**-5,928**	**$140,044,615**		
Lower Cost	*(Children/Parents; Other)*	490,750	425,770	64,980	-5,707	$100,315,184	$204	$214
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	44,030	13,933	30,097	-221	$39,729,432	$902	$953
SoonerCare Traditional		**236,077**	**89,819**	**146,258**	**-2,006**	**$170,419,945**		
Lower Cost	*(Children/Parents; Other)*	124,877	84,792	40,085	-2,275	$45,104,674	$361	$371
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	111,200	5,027	106,173	269	$125,315,271	$1,127	$1,255
SoonerPlan		**38,473**	**2,965**	**35,508**	**-1,700**	**$256,034**	$7	$8
Insure Oklahoma		**17,438**	**332**	**17,106**	**340**	**$5,207,477**		
Employer-Sponsored Insurance		13,518	154	13,364	401	$3,633,748	$269	$278
Individual Plan		3,920	178	3,742	-61	$1,573,729	$401	$459
TOTAL		**826,768**	**532,819**	**293,949**	**-9,294**	**$315,928,072**		

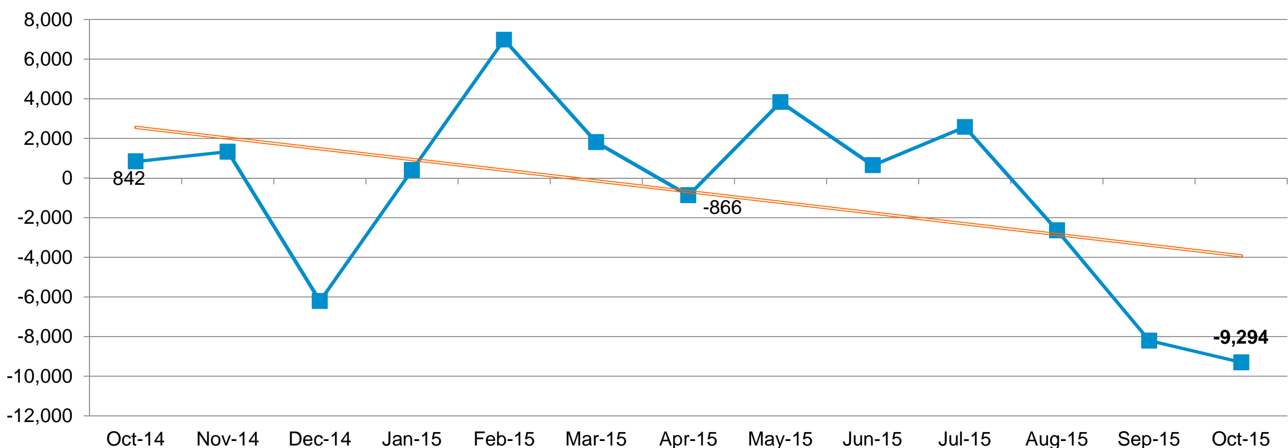
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

Total In-State Providers: 33,769 (+320)			**(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**					
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,689	940	1,211	197	5,309	638	241	6,631	2,523

ENROLLMENT BY MONTH

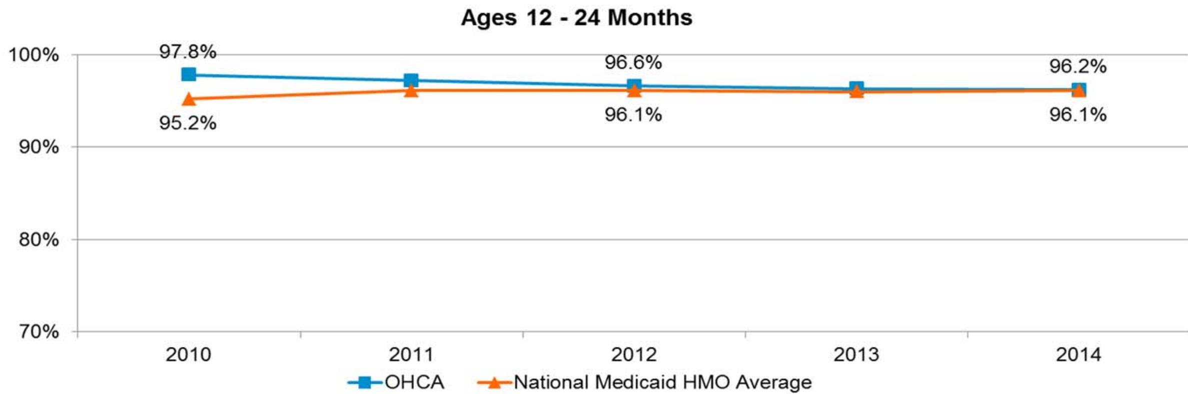


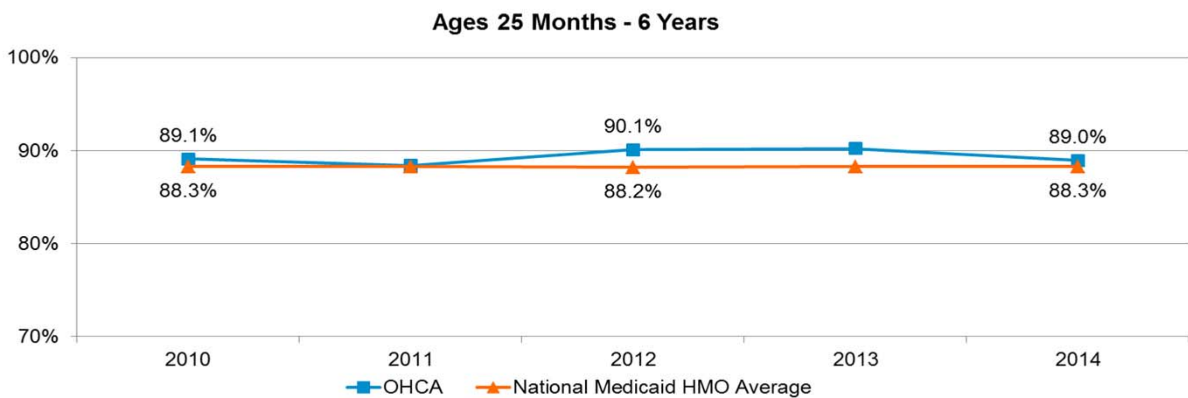
MONTHLY CHANGE IN ENROLLMENT

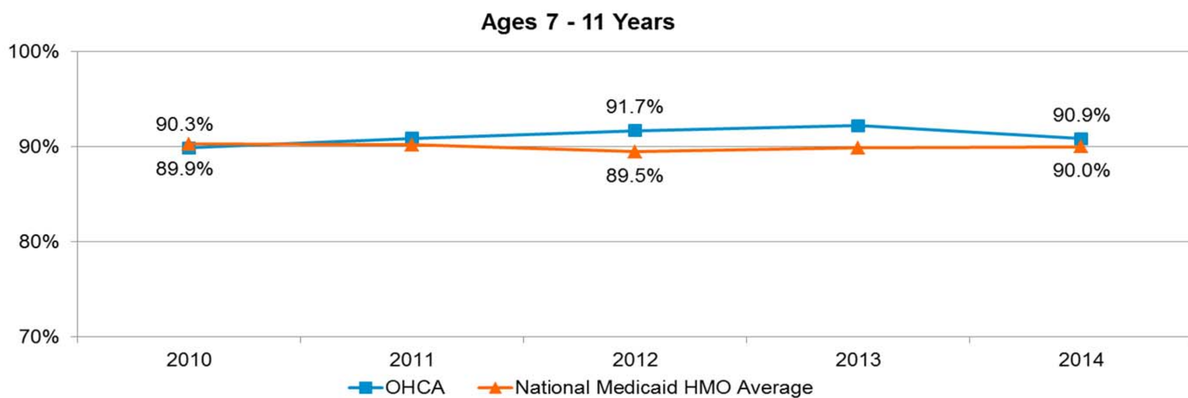


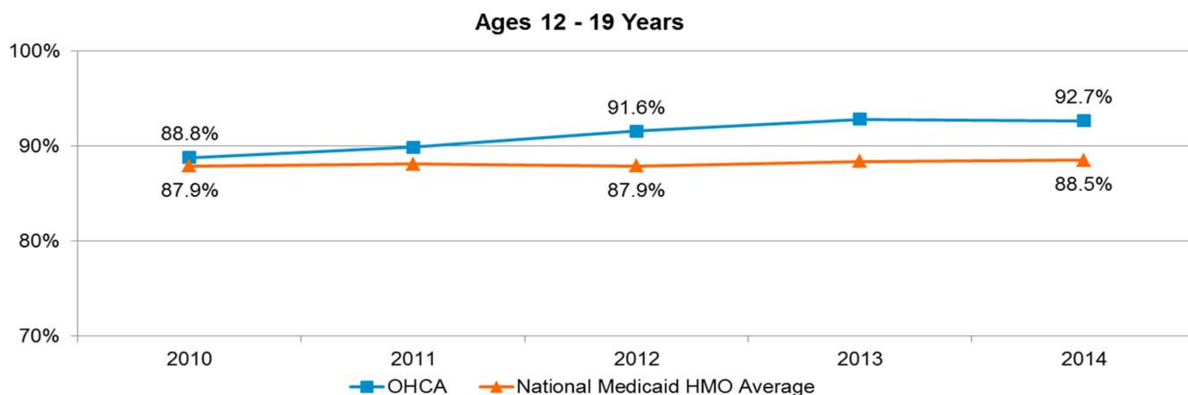
HEDIS QUALITY MEASURES - CHILDREN & ADOLESCENT'S ACCES TO PRIMARY CARE PHYSICIANS

The percentage of members 12 months to 19 years of age who had a visit with a PCP based on specific procedure codes indicating well-child visits. Children 12 months to 6 years had a PCP visit during the measurement year. Children and adolescents 7 to 19 years had a PCP visit during the current or previous measurement year. Members were continuously enrolled during the measurement year(s) with a gap in enrollment of up to 45 days allowed.









ABD CARE COORDINATION MODEL PRESENTATION TO OHCA BOARD

THE PACIFIC HEALTH POLICY GROUP
DECEMBER 10, 2015

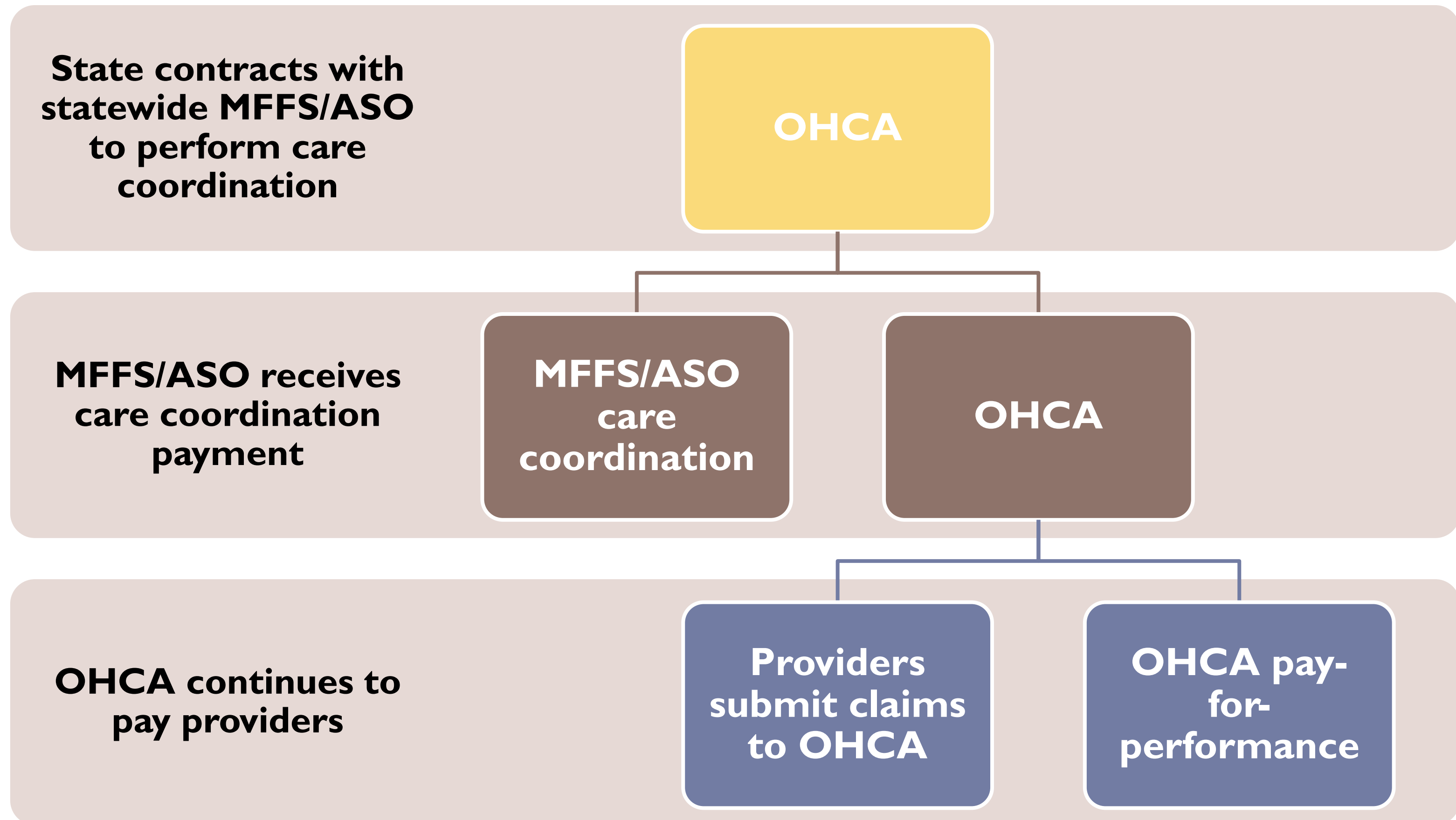
HB 1566

"The Oklahoma Health Care Authority shall initiate requests for proposals for care coordination models for aged, blind and disabled persons. Care coordination models for members receiving institutional care shall be phased in two (2) years after the initial enrollment period of a care coordination program."

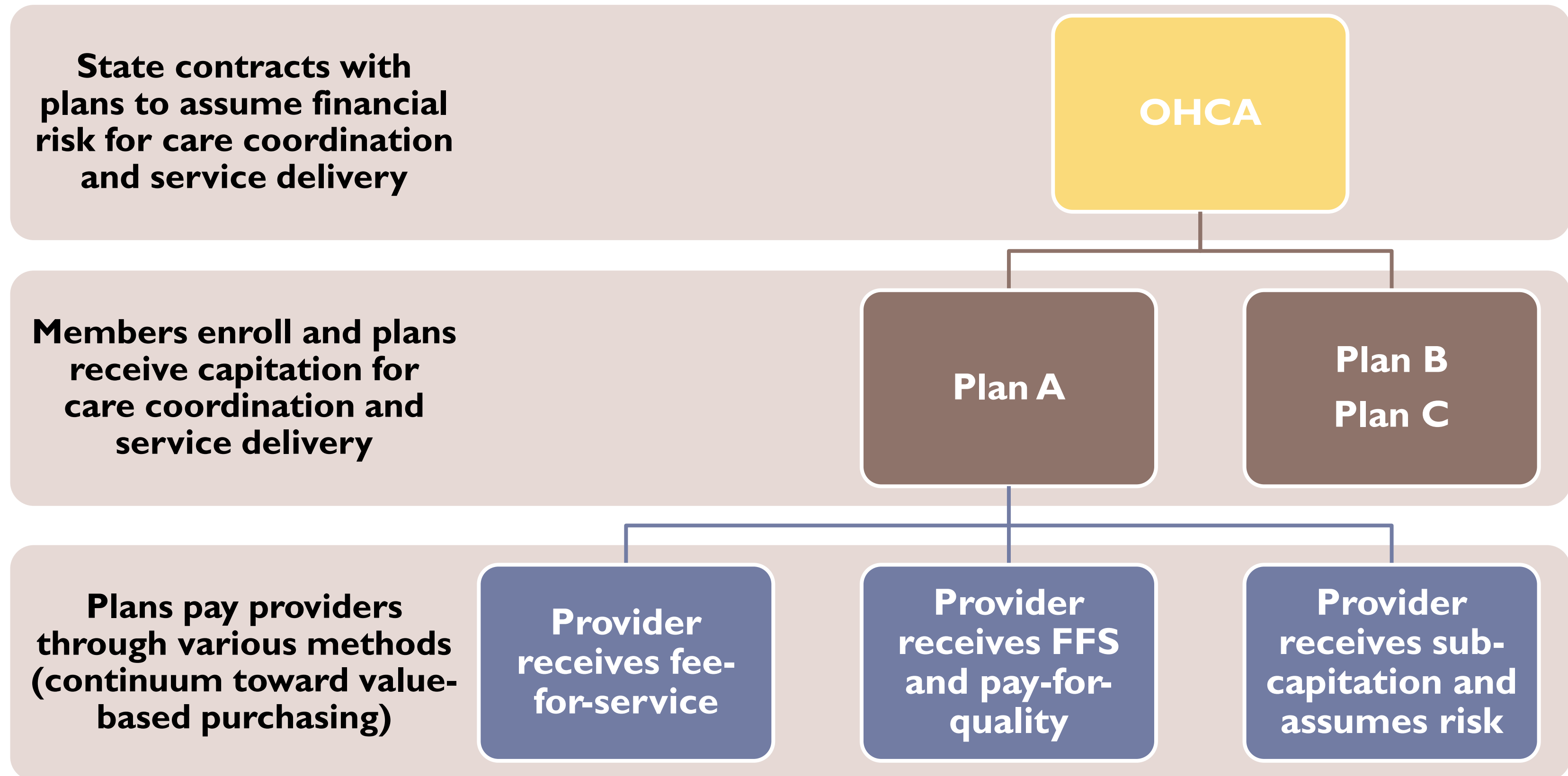
ABD CARE COORDINATION RFI

- The OHCA issued an RFI in June seeking recommendations for ABD care coordination models
- Twenty-two (22) organizations submitted written responses, indicating strong interest
- The primary model proposed was for contracts with capitated health plans
- Several respondents recommended a managed fee-for-service model
- Several regional, community-based provider organizations also expressed an interest in participating

MODEL – MANAGED FFS/ASO



MODEL – CAPITATED HEALTH PLAN



ACTIVITIES SINCE SEPTEMBER

- In September, October and November the OHCA and its consultant gathered information to inform recommendation of a model to the Board
- Stakeholder meetings were held throughout Oklahoma
- The OHCA continues to receive written input from stakeholders (all letters are available on the OHCA website)
- National experts and representatives from states with ABD care coordination programs also have been interviewed to document "best practices" and "lessons learned"

STAKEHOLDER MEETINGS

DATE	LOCATION	ATTENDEES
September 8	OKC	Monthly statewide stakeholder meeting
September 21	McAlester	Regional stakeholder meeting
September 22	Lawton	Regional stakeholder meeting
September 23	Enid	Regional stakeholder meeting
September 29	Muskogee	Regional stakeholder meeting
September 30	Tulsa	Regional stakeholder meeting
October 7	Woodward	Regional stakeholder meeting
October 13	OKC	Monthly statewide stakeholder meeting
November 10	OKC	Monthly statewide stakeholder meeting
October 5	Tahlequah	Elder care members and caregivers
October 6	Ardmore	Parents/support team of medically fragile child
October 7	Oklahoma City	Member/parents of children/adults with I/DD

STAKEHOLDER MEETING ATTENDEES

Providers

- Physicians
- Hospitals
- Federally Qualified Health Centers (primary care, dental, behavioral health)
- IHS/tribal providers
- Non-emergency transportation providers
- ADvantage waiver case managers and in-home service providers
- PACE providers
- I/DD waiver service providers
- Nutrition/home delivered meal providers

Members and Families

- ADvantage waiver and PACE
- I/DD waiver and waiting list
- Medically fragile

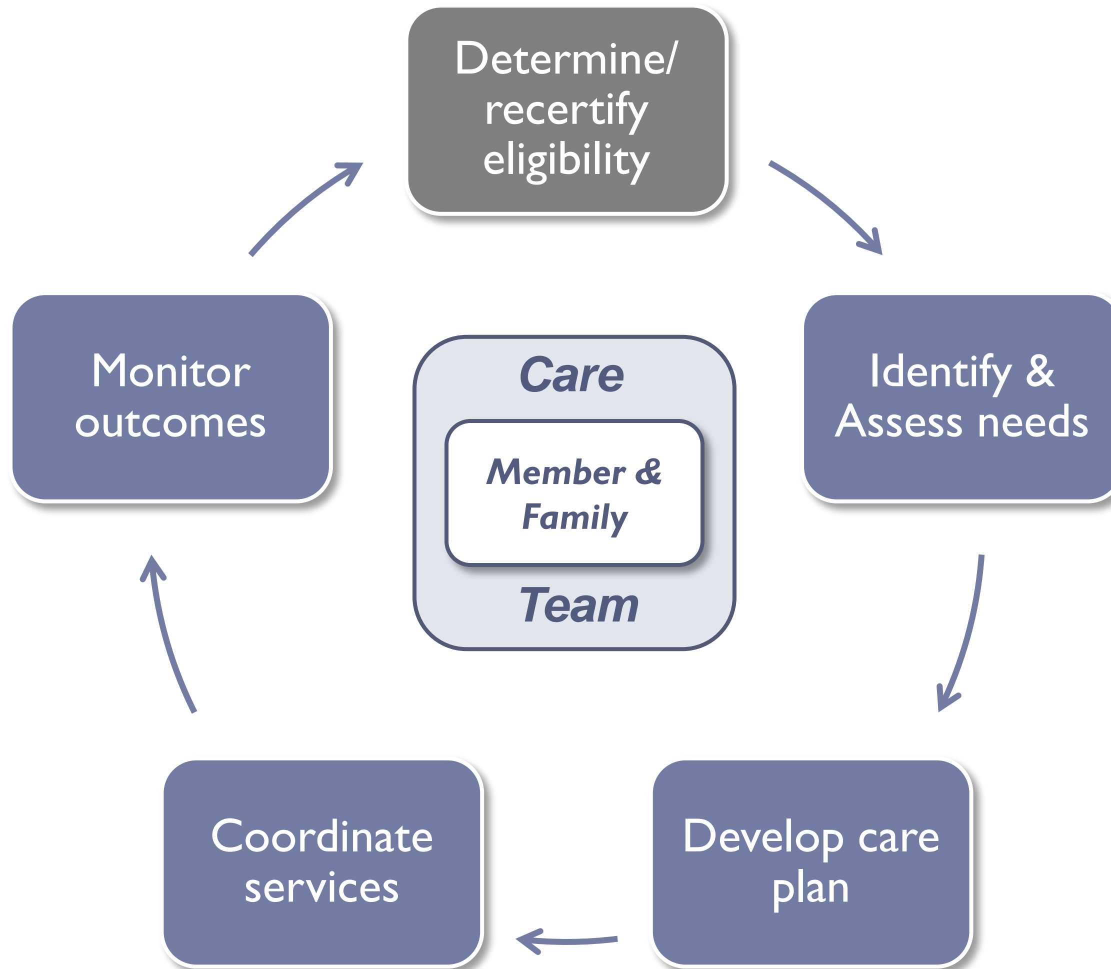
Other

- Elected officials
- State agency representatives (observers)
- Health plans (observers)

CARE COORDINATION CYCLE

- Stakeholder meetings were used in part to define the steps in the care coordination "cycle"
- Stakeholders identified the core principles necessary for effective care coordination
- Stakeholders also offered recommendations for advancing care coordination principles for ABD members, as part of the RFP process

CARE COORDINATION CYCLE



CARE COORDINATION - MODELS

- Stakeholders made 19 recommendations for advancing care coordination principles
  - One eligibility-related recommendation was outside the scope of the RFP
  - The capitated health plan option has the potential to address the remaining 18 recommendations
  - The MFFS/ASO option has the potential to address 14 recommendations
  - The recommendations not addressed by the MFFS/ASO model relate to streamlining service authorizations, improving access and advancing value-based purchasing methods tied to provider quality

CARE COORDINATION – PRINCIPLES

- Eligibility Determination
  - Promote timely start to care coordination and service delivery through efficient eligibility determination process
    - *Automate and streamline the separate financial and clinical eligibility processes to the extent possible (outside of HB1566 and RFP scope)*
    - *Provide support to existing SoonerCare ADvantage waiver and Intellectual/Developmental Disabilities (I/DD) waiver applicants*

CARE COORDINATION - PRINCIPLES

- Identification and Assessment
  - Promote early identification, through outreach, referrals and data analysis, of existing SoonerCare members not receiving care coordination
    - *Attempt to contact all ABD members to conduct an initial health risk assessment (screen)*
    - *Inform all ABD members about care coordination options appropriate to their needs*

CARE COORDINATION - PRINCIPLES

- Develop care plan
  - Integrate all services within care plan, regardless of payer, as well as volunteered services
    - *Ensure every ABD member who needs a comprehensive assessment and care plan receives one, regardless of his/her specific ABD aid category*
    - *Coordinate with, and work alongside, existing programs in which the member may be enrolled (e.g., Health Homes)*

CARE COORDINATION - PRINCIPLES

- Coordinate services
  - Ensure timely delivery of care plan services
    - *Provide care coordination based on member need, regardless of specific ABD aid category*
    - *Streamline, automate and accelerate service authorization process (only capitated health plan model addresses)*
    - *Address service delivery gaps (only capitated health plan model addresses)*

CARE COORDINATION - PRINCIPLES

- Coordinate services *cont'd*
  - Monitor to ensure services are furnished in accordance with care plan
    - *Use Electronic Visit Verification (EVV) to monitor service delivery on a real-time basis for any members receiving in-home services*
    - *Expand qualified Personal Care Assistant (PCA) capacity and use of technology, such as telehealth (only capitated health plan model addresses)*
  - Coordinate ongoing member needs and member transitions
    - *Address critical transition points, such as hospital-to-home discharges*

CARE COORDINATION - PRINCIPLES

- Monitor outcomes
  - Quality: Incorporate nationally validated measures that: encompass the full continuum of care; address Oklahoma priorities; address performance at both the individual and system level; and address both short term and long term performance
    - *Develop a comprehensive quality monitoring process in collaboration with stakeholders (including member-majority advisory committee)*
    - *Reward case managers and providers who meet/exceed goals and take corrective action with others where necessary (only capitated health plan model addresses)*
  - Cost: Track cost effectiveness in a manner that allows for up-front investment to have an impact

CARE COORDINATION - MODELS

- The capitated health plan model would be the better structure for:
  - Fostering partnerships between the contractors and regional, community based providers interested in offering care coordination within their scope-of-competence/geographic care
  - Building on the successes of existing care coordination initiatives, such as the Health Access Networks
- The capitated health plan model also better meets State/OHCA objectives and requirements

STATE/OHCA OBJECTIVES/NEEDS

- In terms of quality, the state must:
  - Be able to hold contractor(s) accountable for performance, including improving quality within each ABD group
  - Ensure that existing care coordination activities are recognized, without adding another layer of care coordination on top of what occurs today
  - Facilitate data integration across care planning, care management and service delivery
  - Address (over time) gaps in provider capacity that impede care plan implementation
- In terms of cost, the state must:
  - Spend no more in the short term than under the current system
  - Achieve savings in the long term as compared to the current system

CC MODELS – STATE/OHCA QUALITY NEEDS

Component	Capitated Health Plan	Managed FFS/ASO
Hold contractor(s) accountable for performance, including improving quality	• Define standards in RFP • Contract with multiple organizations to provide state with maximum leverage	• Define in RFP
Ensure existing care coordination activities are recognized, without adding another layer of care coordination	• Encourage health plan partnerships with existing care coordination entities • Encourage partnerships with regional providers	• Selection of statewide contractor would be coupled with discontinuation of existing activities for ABD members
Facilitate data integration between care planning, care management and service delivery	• Evaluate health plan platform for integration of care planning and management as part of selection process • Evaluate health plan platform for integration with network	• Evaluate ASO platform for integration of care planning and management (integration with network is outside scope)
Address (over time) gaps in provider capacity that impede care plan implementation	• Evaluate health plan strategy for identifying gaps and expanding capacity • Encourage creative payment strategies (P4P)	N/A

CC MODELS – STATE/OHCA COST

Component	Capitated Health Plan	Managed FFS/ASO
Spend no more in the short term than under the current system	• Shift financial risk to plans • Contract at capitation rates that do not exceed current spending	• Contract for care coordination at rates that do not exceed current spending for this activity • State retains risk for provider costs – address constraints using existing tools (rate and benefit reductions)
Achieve savings in the long term as compared to the current system	• Shift financial risk to plans • Build-in trend (inflation) rates below current projections	• Build-in trend line for care coordination rates below current projections for this activity • State could structure shared savings opportunity (e.g., SoonerSilver) but would retain risk for provider costs – address constraints using existing tools (rate and benefit reductions)

CC MODELS – SUMMARY COMPARISON

<table>
<tr><th>Eligibility</th><th>Assessment</th><th>Care Planning</th><th>Service Coordination</th><th>Outcomes Monitoring</th><th>State Quality Objectives</th><th>State Cost Needs</th></tr>
<tr><td rowspan="4">Automate and streamline process</td><td rowspan="2">Conduct initial HRA on all ABD members</td><td rowspan="2">Develop comprehensive care plan for every member who needs one</td><td>Streamline, accelerate and automate service authorizations</td><td rowspan="3">Develop comprehensive quality monitoring process</td><td rowspan="2">Hold contractor(s) accountable for performance</td><td rowspan="4">Spend no more on care coordination in the short term than under current system</td></tr>
<tr><td>Address service delivery gaps</td></tr>
<tr><td rowspan="2">Educate all members about care coordination options</td><td rowspan="2">Promote IDT participation by all appropriate persons</td><td>Use EVV to monitor service delivery</td><td rowspan="2">Ensure existing care coordination activities are recognized</td></tr>
<tr><td rowspan="2">Provide ongoing coordination based on member need</td><td rowspan="2">Reward providers for progress</td></tr>
<tr><td rowspan="3">Provide support to LTSS waiver applicants</td><td rowspan="2">Implement streamlined assessment process</td><td rowspan="2">Educate members about self-directed care option</td><td rowspan="2">Facilitate data integration between care planning, management and service delivery</td><td rowspan="3">Achieve program savings in the long term, as compared to current system, outside of provider rate cuts and benefit reductions</td></tr>
<tr><td>Address critical transition points</td><td rowspan="2">Establish member-majority advisory committee</td></tr>
<tr><td>Use IDT structure to integrate services</td><td>Coordinate with existing programs (if applicable)</td><td>Promote incentives to increase PCA capacity</td><td>Address gaps in provider capacity over time</td></tr>
</table>

CC MODELS – CAPITATED HP SUMMARY

<table>
<tr><th>Eligibility</th><th>Assessment</th><th>Care Planning</th><th>Service Coordination</th><th>Outcomes Monitoring</th><th>State Quality Objectives</th><th>State Cost Needs</th></tr>
<tr><td rowspan="4"></td><td rowspan="2">Conduct initial HRA on all ABD members</td><td rowspan="2">Develop comprehensive care plan for every member who needs one</td><td>Streamline, accelerate and automate service authorizations</td><td rowspan="3">Develop comprehensive quality monitoring process</td><td rowspan="2">Hold contractor(s) accountable for performance</td><td rowspan="4">Spend no more on care coordination in the short term than under current system</td></tr>
<tr><td>Address service delivery gaps</td></tr>
<tr><td rowspan="2">Educate all members about care coordination options</td><td rowspan="2">Promote IDT participation by all appropriate persons</td><td>Use EVV to monitor service delivery</td><td rowspan="2">Ensure existing care coordination activities are recognized</td></tr>
<tr><td rowspan="2">Provide ongoing coordination based on member need</td><td rowspan="2">Reward providers for progress</td></tr>
<tr><td rowspan="3">Provide support to LTSS waiver applicants</td><td rowspan="2">Implement streamlined assessment process</td><td rowspan="2">Educate members about self-directed care option</td><td rowspan="2">Facilitate data integration between care planning, management and service delivery</td><td rowspan="3">Achieve program savings in the long term, as compared to current system, outside of provider rate cuts and benefit reductions</td></tr>
<tr><td>Address critical transition points</td><td rowspan="2">Establish member-majority advisory committee</td></tr>
<tr><td>Use IDT structure to integrate services</td><td>Coordinate with existing programs (if applicable)</td><td>Promote incentives to increase PCA capacity</td><td>Address gaps in provider capacity over time</td></tr>
</table>

CC MODELS – MFFS/ASO SUMMARY

Eligibility	Assessment	Care Planning	Service Coordination	Outcomes Monitoring	State Quality Objectives	State Cost Needs
	Conduct initial HRA on all ABD members	Develop comprehensive care plan for every member who needs one		Develop comprehensive quality monitoring process	Hold contractor(s) accountable for performance	Spend no more on care coordination in the short term than under current system
	Educate all members about care coordination options	Promote IDT participation by all appropriate persons	Use EVV to monitor service delivery			
			Provide ongoing coordination based on member need			
Provide support to LTSS waiver applicants	Implement streamlined assessment process	Educate members about self-directed care option	Address critical transition points	Establish member-majority advisory committee		
	Use IDT structure to integrate services	Coordinate with existing programs (if applicable)				

MODEL RECOMMENDATION

- Move forward with RFP for fully-capitated, statewide health plans
- Encourage partnerships between health plans and regional, community-based providers through RFP selection criteria
- Promote stakeholder participation in quality improvement through RFP standards (e.g., quality advisory committee)

SFY 2015 Tribal Government Relations Report

OHCA Board Meeting – December 10, 2015

BACKGROUND

- OHCA tribal consultation policy
- The annual meeting is intended for OHCA staff and tribal leaders to have an open forum to discuss any topic of relevance to the SoonerCare program and the health care of tribal citizens
- Elected tribal officials and their designees and OHCA executive staff are invited to attend
- Roundtable discussion format

9TH ANNUAL TRIBAL CONSULTATION

- Oct. 20, 2015
- Co sponsor: Oklahoma City Area Inter-Tribal Health Board
- Partial donation of meeting space: Cherokee Nation
- 17 tribes, Indian Health Service, urban Indian health programs represented

Oklahoma HealthCare Authority

9TH ANNUAL TRIBAL CONSULTATION

Oklahoma HealthCare Authority

9TH ANNUAL TRIBAL CONSULTATION

Oklahoma HealthCare Authority

9TH ANNUAL TRIBAL CONSULTATION

- Bi-monthly tribal consultation SFY 2015
  - 63 items considered
  - 34 tribal impact
  - 33 resolved; 1 pending
- Top issues discussed during annual meeting
  - access to care issues for rural tribal communities
  - health care of tribal elders
  - preventive care for chronic diseases (eg. diabetes)
  - need for more mental health services in tribal communities

NEXT STEPS

- OHCA partnership planning session
  - prioritize issues and develop an action plan
  - guide for OHCA and tribal partners for upcoming year
  - 2015 Tribal Action Plan is currently available on the OHCA Tribal Government Relations webpage
    - Living document; reciprocal and transparent communication with tribal partners on any activity for the action plan

Oklahoma HealthCare Authority

TRIBAL PARTNERSHIP ACTION PLAN

Providers

- Types
- Claim Tools
- Forms
- Secure Sites
- Policies & Rules
- Training
- Updates
- Help

Home > Providers > Types

WebAlerts - Click here

2015 OHCA Tribal Partnership Action Plan

Topics identified by tribal partners at Oct. 21, 2014 Annual Tribal Consultation Meeting

To view the 2014 Tribal Partnership Action Plan, click here.

Topic	Objective (What does success look like?)	Activities (What do we need to do?)	Resources Needed (What do we need to get this done?)	Progress Update (What has been done so far?)	Feedback?
1. Health care services reimbursement to ITU providers (ITU Uncompensated Care) (Request from tribal leaders and I/T/U health care providers to OHCA for a waiver to allow payments for services not covered under SoonerCare)	1. Hold tribal nations harmless from state budget reductions and sustain ITU reimbursement to address healthcare disparities.	1A. Tribal partners to lead advocacy efforts and create a timeline in coordination with key legislative representatives (e.g., Letter writing campaign, tribal resolutions, etc.) 1B. Oklahoma City Area Inter-Tribal Health Board will provide progress updates.	1A. Legislative authority or executive order 1B. Approved waiver from Centers for Medicare and Medicaid Services (CMS)	House Bill 1831 (Scott) 55th Legislature Session; failed deadline on 02/26/15	*Click here to provide feedback on this topic.*
2. Chronic disease prevention for SoonerCare tribal citizens (Discussion revealed concerns and importance to address chronic disease prevention among tribal citizens.) Education: nutrition, new meal plans and healthy food choices at ceremonial practices. Intervention: Focus on Head Start programs and tribal youth Staffing: Tobacco cessation representative and wellness staff.	1. Increase from 0 to 1 the number of culturally appropriate health communications campaign for tribal SoonerCare members. 2. Increase from 0 to 1 the number of health intervention efforts with tribal partners tailored to tribal SoonerCare children (e.g., tribal head start, JOM programs, boarding schools, etc.) 3. Increase from 0 to 1 the creation of OHCA/Tribal Public Resource Directory.	1A. OHCA to convene a focus group for development of materials tailored to tribal SoonerCare members 1B. OHCA collaborates with tribal partners to develop culturally appropriate messages that promote healthy living 1C. OHCA to explore cobranding opportunities with tribal partners 1D. OHCA works with tribal partners to develop and implement a health communications plan 2A. OHCA to assess tribal partner needs and current health intervention strategies; propose and implement collaboration for a new intervention	1A. Healthy diet and food preparation resources (e.g., classes, cookbook, recipes, etc.) 1B. Tribal, community and state leadership support	OHCA has partnered with the Oklahoma City Area Inter-tribal Health Board (OCAITHB) to achieve these objectives. - 07/23/15 held first "Tribal Healthy Campaign" focus group at the Oklahoma City Area Inter-tribal Health Board. Attendees: Kaw Nation, Oklahoma City Indian Clinic (OCAITHB), OU Native American studies program, BlueCross/BlueShield. - 09/17/15 The University of Oklahoma Native American Studies Program hosted follow up for "Tribal Healthy Campaign" at Ellison Hall. Attendees: Oklahoma City Area Inter-tribal Health Board, BlueCross/BlueShield and OHCA. - Absentee Shawnee Tribe participated in the 7th Annual Riverside Boarding School Dental Event was held on 08/28/15. 441 students received dental health education.	*Click here to provide feedback on this topic.*

Oklahoma Health Care Authority

TRIBAL GOVERNMENT RELATIONS

Dana Miller, Director
(405) 522-7303
Dana.miller@okhca.org

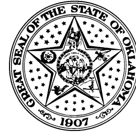
Johnney Johnson, Coordinator
(405) 522-7058
Johnney.johnson@okhca.org

Lucinda Gumm, Coordinator
(405) 522-7248
Lucinda.gumm@okhca.org

Janet Byas, Health Promotion Specialist
(405) 522-7392
Janet.byas@okhca.org

Oklahoma HealthCare Authority

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER



MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

State Plan Amendment Rate Committee (SPARC) Agenda
December 9, 2015 at 2:00PM
OHCA Board Room

Rate Changes or Method Changes to be addressed:

1) 3% Across-the-Board Provider Rate Reduction

   a) Provider Rate Reduction…………………………………………………………………………………….1-2

   b) Medically Fragile Waiver Rate Reduction………………………………………………………………3-4

2) Nursing Home Medicare Part A Crossover Claims Rate Reduction……………………………5-6

3) Direct Skilled Nursing Services

   a) Medically Fragile Waiver Direct Skilled Nursing Services………………………………………7-8

   b) Advantage Waiver Direct Skilled Nursing Services………………………………………………9-10

   c) Developmental Disabilities Services Direct Skilled Nursing Services…………………..11-12

4) Non-Invasive Prenatal Testing (NIPT)…………………………………………………………………13-14

5) Online Telemedicine Visits……………………………………………………………………………………15

State Plan Amendment Rate Committee (SPARC)
December 9, 2015 at 2:00PM

3.00% Across-the-Board Provider Rate Reduction

1. **Is this a "Rate Change" or a "Method Change"?**
   Rate Change

2. **Is this change an increase, decrease, or no impact?**
   Decrease

3. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 3.00% reduction, to the current rates and reimbursement structure in the SoonerCare program. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

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

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

4. **Current methodology and/or rate structure.**
   OHCA currently reimburses providers under a variety of different rate structures; diagnostic-related group (DRG), per diem, max fee, percent of Medicare, and a percent of costs are some examples. Our current rates reflect a 3.25% reduction and a 7.75% reduction from the applicable rate structures, implemented in April of 2010 and July 2014.

5. **New methodology or rate.**
   Effective January 1, 2016, OHCA seeks to decrease the current applicable rates by 3.00% of the applicable rate structure.

   The proposed reduction excludes services financed through appropriations to other state agencies, services provided under a waiver, and services where a reduction could severely limit access or not cover costs (in the aggregate). While this list is fairly comprehensive it is not exhaustive.

   - Complex Rehabilitation Technology Provider Services
   - Long term care facilities
   - Child abuse exams

- Non-emergency transportation
- Insure Oklahoma
- Payments for drug ingredients / physician supplied drugs
- Services provided under a waiver (except Living Choice Demonstration which is included on this brief and Medically Fragile Waiver which will be mentioned in the following brief)
- Services paid for by other state agencies, excluding school based services
- Services provided to Native Americans through Indian Health Services / Indian/Tribal/Urban Clinics

6. **Budget estimate.**
Savings for the remainder of SFY2016 will be a decrease in the total amount of $25,917,478; $8,343,579 state share. The estimated savings for SFY2017 will be a decrease in the total amount of $50,770,065; $20,206,485 state share.

7. **Agency estimated impact on access to care.**
The Oklahoma Health Care Authority does not anticipate any impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

8. **Rate or Method change in the form of a motion.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the 3.00% rate reduction for all providers excluding those providers/services that have an exception provision.

9. **Effective date of change.**
January 1, 2016

State Plan Amendment Rate Committee (SPARC)
December 9, 2015 at 2:00PM

3.00% Medically Fragile Waiver Rate Reduction

1. **Is this a “Rate Change” or a “Method Change”?**
   Rate Change

2. **Is this change an increase, decrease, or no impact?**
   Decrease

3. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 3.00% reduction, to the current rates and reimbursement structure in the SoonerCare program. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

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

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

4. **Current methodology and/or rate structure.**
   The current Medically Fragile Waiver rate structure for services for which a rate reduction is being implemented is a fixed and uniform rate configuration established through the State Plan Amendment Rate Committee process.

5. **New methodology or rate.**
   Effective January 1, 2016, OHCA seeks to decrease the current Medically Fragile Waiver rates by 3.00%.

6. **Budget estimate.**
   Savings for the remainder of SFY2016 will be a decrease in the total amount of $21,335; $8,323 state share. The estimated savings for SFY2017 will be a decrease in the total amount of $128,009; $50,947 state share.

7. **Agency estimated impact on access to care.**
   The Oklahoma Health Care Authority does not anticipate any impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of the rate

reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

8. **Rate or Method change in the form of a motion.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the proposed 3% Medically Fragile Waiver rate reduction.

9. **Effective date of change.**
The effective date for the rate decrease is April 1, 2016.

State Plan Amendment Rate Committee (SPARC)
December 9, 2015 at 2:00PM

Nursing Home Medicare Part A Cross-Over Claims Reduction

1. **Is this a "Rate Change" or a "Method Change"?**
   Method Change

2. **Is this change an increase, decrease, or no impact?**
   Decrease

3. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current methodology for payment of crossovers.

   The Oklahoma Health Care Authority Board must take action to reduce SoonerCare expenditures to file a balanced budget. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **Current methodology and/or rate structure.**
   OHCA current rate methodology pays 75% of Medicare Part A coinsurance and deductible on crossover claims to nursing homes.

5. **New methodology or rate.**
   The proposed rate methodology is to pay 20% of Medicare Part A coinsurance and deductible on crossover claims to nursing homes.

6. **Budget estimate.**
   Savings for the remainder of SFY2016 will be a decrease in the total amount of $6,130,523; $2,391,517 state share. The estimated savings for SFY2017 will be a decrease in the total amount of $12,017,673; $4,783,034 state share.

7. **Agency estimated impact on access to care.**
   The Oklahoma Health Care Authority does not anticipate any impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any

positive or negative impact to access or quality of care. In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

8. **Rate or Method change in the form of a motion.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the method change to pay 20% of Coinsurance and Deductible of Medicare Part A Crossover claims to nursing homes.

9. **Effective date of change.**
January 1, 2016

State Plan Amendment Rate Committee (SPARC)
December 9, 2015 at 2:00PM

Medically Fragile Waiver Direct Skilled Nursing Services

1. **Is this a "Rate Change" or a "Method Change"?**
Rate Change (New Code Added)

2. **Is this change an increase, decrease, or no impact?**
No Impact

3. **Presentation of issue – Why is change being made?**
The Oklahoma Health Care Authority (OHCA) recommends adding two new codes G0299 Direct skilled nursing services of a registered nurse (RN) and G0300 Direct skilled nursing of a licensed practical nurse (LPN).

   The Centers for Medicare and Medicaid Services (CMS) has established new G-codes to differentiate levels of nursing services provided during a hospice stay and a home health episode of care.

4. **Current methodology and/or rate structure.**
The current rate structures for direct skilled nursing services are billed utilizing code G0154 for both RNs and LPN.

Service Description	Code	Current Rate	Unit
Skilled Nursing	G0154	$13.50	15 minutes

5. **New methodology or rate.**
The table below indicates the new proposed codes and rates.

Service Description	**Code**	**Rate**	**Unit**
Skilled Nursing – Registered Nurse	G0299	$13.50	15 minutes
Skilled Nursing – Licensed Practical Nurse	G0300	$13.50	15 minutes

6. **Budget estimate.**
The addition of two new codes (G0299 and G0300) will result in no budget impact since the existing codes G0154 is currently being paid at the same rate of the two new proposed codes.

7. **Agency estimated impact on access to care.**
The development of two new codes will not have an impact to access and quality of care to SoonerCare members.

8. **Rate or Method change in the form of a motion.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate

Committee approve adding two new codes G0299 - Direct skilled nursing services of a registered nurse (RN) and G0300 - Direct skilled nursing of a licensed practical nurse (LPN) and establishing the $13.50 rate.

9. **Effective date of change.**
   January 1, 2016

State Plan Amendment Rate Committee (SPARC)
December 9, 2015 at 2:00PM

ADvantage Waiver Direct Skilled Nursing Services

1. **Is this a "Rate Change" or a "Method Change"?**
Rate Change (New Code Added)

2. **Is this change an increase, decrease, or no impact?**
No Impact

3. **Presentation of issue – Why is change being made?**
The Oklahoma Department of Human Services (DHS) recommends adding two new codes G0299 Direct skilled nursing services of a registered nurse (RN) and G0300 Direct skilled nursing of a licensed practical nurse (LPN).

   The Centers for Medicare and Medicaid Services (CMS) has established new G-codes to differentiate levels of nursing services provided during a hospice stay and a home health episode of care.

4. **Current methodology and/or rate structure.**
The current rate structures for direct skilled nursing services are billed utilizing code G0154 for both RNs and LPN.

Service Description	Code	Current Rate	Unit
Skilled Nursing	G0154	$13.50	15 minutes
Extended State Plan Skilled Nursing	G0154 TF	$13.50	15 minutes

5. **New methodology or rate.**
The table below indicates the new proposed codes and rates.

Service Description	**Code**	**Rate**	**Unit**
Skilled Nursing – Registered Nurse	G0299	$13.50	15 minutes
Extended State Plan Skilled Nursing	G0299 TF	$13.50	15 minutes
Skilled Nursing – Licensed Practical Nurse	G0300	$13.50	15 minutes
Extended State Plan Skilled Nursing	G0300 TF	$13.50	15 minutes

6. **Budget estimate.**
The addition of two new codes (G0299 and G0300) will result in no budget impact since the existing codes G0154 is currently being paid at the same rate of the two new proposed codes.

7. **Agency estimated impact on access to care.**
The development of two new codes will not have an impact to access and quality of care to SoonerCare members.

8. **Rate or Method change in the form of a motion.**
   The agency requests the State Plan Amendment Rate Committee approve adding two new codes G0299 - Direct skilled nursing services of a registered nurse (RN) and G0300 - Direct skilled nursing of a licensed practical nurse (LPN) and establishing the $13.50 rate.

9. **Effective date of change.**
   January 1, 2016

State Plan Amendment Rate Committee (SPARC)
December 9, 2015 at 2:00PM

Developmental Disabilities Services Direct Skilled Nursing Services

1. **Is this a "Rate Change" or a "Method Change"?**
   Rate Change (New Code Added)

2. **Is this change an increase, decrease, or no impact?**
   No Impact

3. **Presentation of issue – Why is change being made?**
   The Oklahoma Department of Human Services (DHS), Developmental Disabilities Services (DDS) recommends adding two new codes G0299 Direct skilled nursing services of a registered nurse (RN) and G0300 Direct skilled nursing of a licensed practical nurse (LPN).

   The Centers for Medicare and Medicaid Services (CMS) has established new G-codes to differentiate levels of nursing services provided during a hospice stay and a home health episode of care.

4. **Current methodology and/or rate structure.**
   The current rate structures for direct skilled nursing services are billed utilizing code G0154 for both RNs and LPN.

Service Description	Code	Current Rate	Unit
Skilled Nursing	G0154	$13.50	15 minutes

5. **New methodology or rate.**
   The table below indicates the new proposed codes and rates.

Service Description	**Code**	**Rate**	**Unit**
Skilled Nursing – Registered Nurse	G0299	$13.50	15 minutes
Skilled Nursing – Licensed Practical Nurse	G0300	$13.50	15 minutes

6. **Budget estimate.**
   The addition of two new codes (G0299 and G0300) will result in no budget impact since the existing codes G0154 is currently being paid at the same rate of the two new proposed codes.

7. **Agency estimated impact on access to care.**
   The development of two new codes will not have an impact to access and quality of care to SoonerCare members.

8. **Rate or Method change in the form of a motion.**

The agency requests the State Plan Amendment Rate Committee approve adding two new codes G0299 - Direct skilled nursing services of a registered nurse (RN) and G0300 - Direct skilled nursing of a licensed practical nurse (LPN) and establishing the $13.50 rate.

9. **Effective date of change.**
January 1, 2016

State Plan Amendment Rate Committee (SPARC)
December 9, 2015 at 2:00PM

Non-Invasive Prenatal Testing (NIPT)

1. **Is this a "Rate Change" or a "Method Change"?**
   Rate Change

2. **Is this change an increase, decrease, or no impact?**
   Increase

3. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends adding a rate for codes (81420 and 81507) for non-invasive prenatal testing (NIPT). This is to provide NIPT for women with high-risk pregnancies (i.e. women over 35 and/or women who have had a positive conventional screen).

4. **Current methodology and/or rate structure.**
   There is no set price for 81420 or 81507. Historically, NIPT has not been a covered service because the test was considered investigational and experimental.

5. **New methodology or rate.**
   OHCA would like to set a rate for procedure codes 81420 and 81507 based on quotes received from providers of the NIPT service. OHCA reached out to NIPT providers and the best rate received was $395, thus OHCA proposes the rate of $395 for both codes. The technology for NIPT is now well-established and no longer considered investigational. The service is covered by most private payers and also some other State Medicaid agencies. Professional associations such as the American Congress of Obstetricians and Gynecologists (ACOG) and the American College of Medical Genetics and Genomics (ACMG) have released guidelines and opinions recommending that NIPT be an option for pregnant women at higher risk of having a pregnancy affected by Down Syndrome, Trisomy 18, or Trisomy 13.

6. **Budget estimate.**
   The rate change will result in an annual budget increase of approximately $953,530 total dollars, $371,972 state share. This is based on 2,414 high risk women @ $395 per test. The number of high risk women is estimated using data from Sequenom (one of the NIPT providers) on actual utilization in the commercial population (where NIPT is covered) along with estimates of Sequenom's market share and OHCA's share of OK pregnancies. To ensure services provided under the SoonerCare program adhere to the national standard of care, funding for NIPT is included in the OHCA's budget.

7. **Agency estimated impact on access to care.**
   This rate change should not have a negative impact to access and quality of care to SoonerCare members.

8. **Rate or Method change in the form of a motion.**

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the adding the procedure codes 81420 and 81507 with a rate of $395 for Non-Invasive Prenatal Testing for women with high-risk pregnancies.

9. **Effective date of change.**
January 1, 2016

State Plan Amendment Rate Committee (SPARC)
December 9, 2015 at 2:00PM

Online Telemedicine Visits

1. **Is this a "Rate Change" or a "Method Change"?**
   Rate Change

2. **Is this change an increase, decrease, or no impact?**
   New rate / New code

3. **Presentation of issue – Why is change being made?**
   To add CPT Codes 99444 - Online Medical Service provided by a physician and 98969 – Online Medical Service provided by an ARNP or PA.

4. **Current methodology and/or rate structure.**
   None

5. **New methodology or rate.**
   OHCA would like to set a rate for procedure codes 99444 (online medical service provided by a physician) and 98969 (online medical service provided by an ARNP or PA) based on current market rate for this service. The proposed rate would be $45.

6. **Budget estimate.**
   No initial budget impact; possible long-term savings from avoided ER visits and/or clinic visits.

7. **Agency estimated impact on access to care.**
   Improved access to care.

8. **Rate or Method change in the form of a motion.**
   The agency requests the State Plan Amendment Rate Committee approve the $45.00 rate for code 99444 and 98969 for the Oklahoma Medicaid program

9. **Effective date of change.**
   January 1, 2016

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

SUBCHAPTER 1. ADVANTAGE WAIVER SERVICES

317:35-17-5. ADvantage program medical eligibility determination

The ~~OKDHS~~Oklahoma Department of Human Services(DHS) area nurse, or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT)Parts I~~, Part~~ and III, and other ~~available~~ medical information.

(1) When ADvantage care services are requested or the UCAT I is received in the county office, the:

(A) ~~the OKDHS~~DHS nurse is responsible for completing the UCAT III~~.~~;and

(B) ~~the~~ social ~~worker~~service specialist is responsible for contacting the ~~individual~~applicant within three ~~working~~business days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. If a categorical relationship to disability ~~has~~was not ~~already been~~ established, the local social ~~worker~~service specialist submits the same information ~~described in OAC~~per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship to the ~~disabled~~person with the disability using the ~~same definition used by SSA~~Social Security Administration (SSA) definition. A follow-up is required by the ~~OKDHS~~DHS social ~~worker~~service specialist with ~~the Social Security Administration~~SSA to ~~be sure their~~ensure the disability decision agrees with the LOCEU decision ~~of LOCEU~~.

(3) Community agencies complete the UCAT~~, Part~~ I, and ~~forwards~~forward the form to the county office. ~~If~~When the UCAT~~, Part~~ I indicates ~~that~~ the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources. Members may also call the care line at 800-435-4711.

(4) The ~~OKDHS~~DHS nurse ~~completes the UCAT, Part III assessment visit~~visits with the member within 10 ~~working~~business days of receipt of the referral for ADvantage services for ~~a client~~an applicant who is Medicaid eligible at the time of the request. The ~~OKDHS~~DHS nurse completes the UCAT~~, Part~~ III assessment within 20 ~~working~~business days of the date the Medicaid application is completed for new applicants.

(5) During the assessment visit, the ~~OKDHS~~DHS nurse informs the applicant of medical eligibility and provides information about the different long-term care service options. ~~If~~When there are

multiple household members applying for the ADvantage program, the UCAT assessment is done for ~~the applicant household members~~them during the same visit. The ~~OKDHS~~DHS nurse documents whether the member chooses ~~NF~~nursing facility program services or ADvantage program services~~. In addition, the OKDHS nurse~~and makes a level of care and service program recommendation.

(6) The ~~OKDHS~~DHS nurse informs the member and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the ~~client's~~applicant's primary and secondary informed choices~~.~~,ensuring adherence to conflict free case management requirements

(A) ~~If the member and/or family declines to make a provider choice, the OKDHS nurse documents that decision on the member choice form.~~Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services.

(B) ~~The AA uses a rotating system to select an agency for the member from a list of all local certified case management and in-home care agencies.~~If the member and/or family declines to make a provider choice, the DHS nurse documents the decision on Form 02CB001, Member Consents and Rights.

(C) The AA uses a rotating system to select an agency for the member from a list of all local, certified case management and in-home care agencies, ensuring adherence to conflict free case management requirements.

(7) The ~~OKDHS~~DHS nurse documents the names of the chosen agencies and the agreement ~~(by dated signature)~~ of the member, by dated signature, to receive services provided by the agencies.

(8) ~~If~~When the ~~needs of the member~~member's needs require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the ~~OKDHS~~DHS nurse documents the need for priority processing.

(9) The ~~OKDHS~~DHS nurse scores the UCAT, Part III. The ~~OKDHS~~DHS nurse forwards the UCAT, Parts I and III, documentation of financial eligibility, ~~and~~ documentation of the member's case management and in-home care agency choices to the area nurse, or nurse designee, for medical eligibility determination.

(10) If, based upon the information obtained during the assessment, the ~~OKDHS~~DHS nurse determines ~~that~~ the member may be at risk for health and safety, ~~OKDHS~~DHS Adult Protective Services ~~(APS)~~ staff ~~are~~is notified immediately and the referral is documented on the UCAT.

(11) Within ~~ten working~~10 business days of receipt of a complete ADvantage application, the area nurse~~,~~ or nurse designee,

determines medical eligibility using ~~NF~~nursing facility level of care criteria and service eligibility criteria ~~[refer to~~per OAC 317:35-17-2 and ~~OAC~~ 317:35-17-3~~]~~ and enters the medical decision on the system.

(12) Upon notification of financial eligibility from the social ~~worker~~service specialist, medical eligibility ~~(MS-52~~), and approval for ADvantage entry from the area nurse~~,~~ or nurse designee, the AA communicates with the case management provider to begin care ~~plan~~ and service plan development. The AA communicates to the ~~client's~~ case management provider, the member's name, address, case number, ~~and social security~~Social Security number, the number of units of case management and, ~~if~~when applicable, the number of units of home health agency nurse evaluation authorized for ~~care plan and~~ service plan development. ~~If~~When the member requires an immediate home visit to develop a service plan within 24 hours, the AA contacts the case management provider directly to confirm availability and ~~then~~ sends the new case packet information to the case management provider via ~~facsimile~~email.

(13) ~~If~~When the services must be in place to ensure the health and safety of the member upon discharge to the home from the ~~NF~~nursing facility or ~~Hospital~~hospital, a ~~nurse~~ case manager from an ADvantage case management provider selected by the ~~client~~member and referred by the AA follows the ADvantage ~~Institution Transition~~institution transition, case management procedures for care ~~plan~~ and service plan development and implementation.

(14) A new medical level of care determination is required when a member requests any ~~of the following~~ changes in service program, from:

(A) ~~from~~ State Plan Personal Care to ADvantage services~~.~~;

(B) ~~from~~ ADvantage to State Plan Personal Care services~~.~~;

(C) ~~from Nursing Facility~~nursing facility to ADvantage services~~.~~; or

(D) ~~from~~ ADvantage to ~~Nursing Facility~~nursing facility services.

(15) A new medical level of care determination is not required when a member requests re-activation of ADvantage services after a short-term stay ~~(~~of 90 calendar-days or less~~)~~ in a ~~Nursing Facility~~nursing facility when the member has had previous ADvantage services and the ADvantage certification period has not expired.

(16) When a UCAT assessment ~~has been~~was completed more than 90 calendar-days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are ~~as follows~~:

(1) **Case ~~Management~~management.**

(A) Case ~~Management~~management services ~~are services that~~ assist a member in gaining access to medical, social, educational, or other services, regardless of payment source ~~of services,~~ that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish ~~waiver~~Waiver program eligibility. Case managers develop the member's comprehensive service plan ~~of care~~, listing only services ~~which are~~ necessary to prevent institutionalization of the member, as determined through the assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan ~~of care~~ reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. ~~If~~When a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay, ~~and~~ helps the member transition from institution to home by updating the service plan, and preparing services to start on the date the member is discharged from the institution. Case ~~Managers~~managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other

ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), ~~Case Managers~~case manager supervisors and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate ~~competency in Person-centered planning~~ person-centered planning competency.

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

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

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

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

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

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

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

(2) **Respite.**

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

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

(C) ~~Facility-Based Extended Respite~~Facility-based extended respite is filed for a per diem rate ~~if~~when provided in ~~Nursing Facility~~a nursing facility. Extended ~~Respite~~respite must be at least eight hours in duration.

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

(3) **Adult ~~Day Health Care~~ day health care.**

(A) Adult ~~Day Health Care~~day health care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services ~~which are~~ necessary to ensure the member's optimal functioning ~~of the member~~. Physical, occupational, and~~/or~~ speech therapies ~~may~~are only ~~be~~ provided as an enhancement to the basic ~~Adult Day Health Care~~adult day health care service when authorized by the service plan ~~of care~~ and are billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Personal ~~Care~~care service enhancement in ~~Adult Day Health Care~~adult day health care is assistance in bathing, ~~and/or~~ hair ~~washing~~care, or laundry service, authorized by the service

plan ~~of care~~ and billed as ~~a~~ separate ~~procedure~~procedures. Most assistance with activities of daily living (ADL), such as eating, mobility, toileting, and nail care~~,~~ are ~~services that are~~ integral services to ~~the Adult Day Health Care~~adult day health care service and are covered by the ~~Adult Day Health Care~~adult day health care basic reimbursement rate. Assistance with bathing, hair care, or laundry service is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing, hair care, or laundry ~~will be~~service is authorized when an ADvantage ~~waiver~~Waiver member who uses adult day health care requires assistance with bathing, hair care, or laundry service to maintain his or her health and safety.

(B) Adult ~~Day Health Care~~day health care is a 15-minute unit of service. No more than ~~8~~eight hours, ~~(~~32 units~~)~~, are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan ~~of care~~.

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

(D) Adult ~~Day Health Personal Care Enhancement~~day health personal care enhancement is a maximum of one unit per day ~~unit~~ of bathing, hair care, or laundry service.

(4) **Environmental ~~Modifications~~modifications.**

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

(B) All services require prior authorization.

(5) **Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies.**

(A) Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies are devices, controls, or appliances specified in the service plan ~~of care, which~~that enable members to increase ~~their abilities~~his or her ability to perform ~~activities of daily living~~ADLs, or to perceive, control, or communicate with the environment in which they live. ~~Also included are items necessary~~Necessary items for life support, ancillary supplies, and equipment necessary ~~to~~for the proper functioning of such items, and

durable and non-durable medical equipment not available under the Medicaid state plan are also included. This service excludes any equipment and/or supply items ~~which are~~ not of direct medical or remedial benefit to the ~~waiver~~Waiver member. This service is necessary to prevent institutionalization.

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

(6)**Advanced~~Supportive/RestorativeAssistance~~supportive/restorative assistance**.

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

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

(7) **Nursing.**

(A) Nursing services are services listed in the service plan ~~of care which~~that are within the scope of the Oklahoma Nursing Practice Act. ~~and~~ These services are provided by a registered ~~professional~~ nurse(RN), ~~or~~a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of ~~a registered nurse,~~an RN licensed to practice in the ~~State~~state. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service ~~will work~~works to prevent or postpone the institutionalization of the member.

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

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

(I) ~~the~~ member's general health, functional ability<u>,</u> and needs<u>;</u> and/or

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

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

(I) ~~preparing~~<u>prepare</u> a one-week supply of insulin syringes for a ~~blind diabetic~~<u>person who is blind and has diabetes,</u> who can safely self-inject the medication but cannot fill ~~his/her~~<u>his or her</u> own syringe. This service ~~would include~~<u>includes</u> monitoring the member's continued ability to self-

administer the insulin;

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

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

(IV) ~~providing~~provide nail care for the ~~diabetic~~ member with diabetes or member ~~with~~who has circulatory or neurological compromise;

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

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

(8) **Skilled ~~Nursing Services~~nursing services.**

(A) Skilled ~~Nursing Services~~nursing services listed in the service plan ~~of carewhich~~that are within the scope of the ~~State's~~state's Nurse Practice Act and are ordered by a licensed ~~medical~~ physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by ~~a registered professional nurse, or licensed practical or vocational nurse~~an RN, or an LPN or LVN under the supervision of a registered nurse, licensed to practice in the ~~State~~state. Skilled ~~Nursing~~nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage ~~Nursing Services~~nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. ~~It is the responsibility of the RN to contact~~The RN contacts the member's physician to obtain ~~any~~ necessary information or orders pertaining to the member's care ~~of the member~~. ~~If~~When the member has an ongoing need for service activities~~, which require~~requiring more or less units than authorized, the RN ~~shall~~must recommend, in writing, that the ~~Plan of Care~~service plan be revised.

(B) Skilled ~~Nursing~~nursing services are provided on an intermittent or part-time basis, and billed ~~in units of~~ per 15-minute ~~increments~~units of service. ~~ADvantage~~ Skilled ~~Nursing~~nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services ~~furnished under SoonerCare plan limits~~ are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's service plan.

(9) **Home ~~Delivered Meals~~ delivered meals.**

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

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

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

(10) **Occupational ~~Therapy Services~~therapy services.**

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

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

(11) **Physical ~~Therapy Services~~therapy services.**

(A) Physical ~~Therapy~~therapy services are those services that ~~prevent~~maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use

of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the ~~limits~~limitations of ~~their~~his or her practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services~~, where~~when appropriate. The licensed physical therapist ~~will ensure~~ensures monitoring and documentation of the member's rehabilitative progress and ~~will report~~reports to the member's case manager and physician to coordinate the necessary addition ~~and/~~or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(12) **Speech and ~~Language Therapy Services~~language therapy services.**

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

member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(13) **Hospice ~~Services~~services.**

(A) Hospice ~~is~~services are palliative and~~/or~~ comfort care provided to the member and ~~his/her~~his or her family when a physician certifies ~~that~~ the member has a terminal illness, ~~and has six months or less to live~~with a life expectancy of six months or less, and orders hospice care. ADvantage ~~Hospice Care~~hospice care is authorized for a six-month period, and requires ~~a~~ physician certification of a terminal illness and orders of hospice care. ~~If~~When the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member ~~thirty~~30-calendar days prior to the initial hospice authorization end date, and re-certify that the member has a terminal illness, ~~and~~ has six months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage ~~Hospice~~hospice may be authorized for a maximum of 60-calendar day increments with physician certification that the member has a terminal illness and ~~has~~ six months or less to live. A member's service plan that includes hospice care must comply with ~~waiver~~Waiver requirements to be within total service plan cost limits.

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

~~conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services. A hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.~~

(C) A hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

~~(C)~~(D) Hospice services are billed per diem of service for days covered by a ~~Hospice~~hospice plan of care and ~~during which~~while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's ~~Hospice~~hospice care within a ~~twelve~~12-month period is limited to an amount equivalent to 85~~%~~percent of the Medicare ~~Hospice Cap~~hospice cap payment, and must be authorized on the member's service plan.

(14) **ADvantage ~~Personal Care~~ personal care.**

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

~~and~~or the ~~operation/maintenance~~operation and maintenance of equipment of a technical nature.

(B) ADvantage ~~Home Care Agency Skilled Nursing~~home care agency skilled nursing staff working in coordination with an ADvantage ~~Case Manager~~case manager are responsible for the development and monitoring of the member's ~~Personal Care plan~~personal care services.

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

(15) **Personal ~~Emergency Response System~~emergency response system.**

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

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

(ii) member lives alone and ~~has no~~without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

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

(vi)The service avoids premature or unnecessary institutionalization of the member.(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service, or PERS purchase ~~of PERS~~. All services are prior-authorized in accordance with the ADvantage approved service plan ~~of care~~.

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

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

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

(ii) ~~provides~~is solely responsible to provide instruction and training to the PSA or APSA on tasks ~~to be done~~ and works with the ~~Consumer Directed Agent/Case Manager~~consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an ~~Advanced Personal Services Assistance~~APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ~~ASPA's~~APSA's personnel file;

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

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

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

(B) The ~~service~~services the~~Personal Services Assistance~~PSA may provide include:

(i) assistance with mobility and ~~with transfer~~transferring in and out of bed, wheelchair, or motor vehicle, or ~~both~~all;

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming; and

(III) eating, including meal preparation and cleanup;

(iii) assistance with ~~homemaker type~~home services that may include shopping, laundry service, cleaning, and seasonal chores;

(iv) companion ~~type~~ assistance that may include letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, ~~that~~and may include shopping for food, clothing, or other necessities, or for participation in other activities or events ~~that are~~ specifically approved on the service plan.

(C) ~~Advanced Personal Services Assistance are maintenance services provided to assist~~An APSA provides assistance with ADLs to a member with a stable, chronic condition ~~with activities of daily living~~, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the ~~individual~~member were physically capable, and the procedure may be safely performed in the home. ~~Advanced Personal Services Assistance is a~~Services provided by the APSA are maintenance ~~service~~services and ~~should~~are never ~~be~~ used as ~~a~~ therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving ~~Advanced Personal Services Assistance~~APSA services ~~should be~~are referred to ~~their~~his or her attending physician, who ~~may, if~~when appropriate, order home health services. ~~The service of Advanced Personal Services Assistance~~APSA includes assistance with health maintenance activities that may include:

(i) routine personal care for persons with ostomies, ~~(~~including tracheotomies, gastrostomies, and colostomies with well-healed stoma~~)~~, ~~and~~ external, indwelling, and suprapubic catheters ~~which includes~~that

include changing bags and soap and water hygiene around the ostomy or catheter site;

(ii) ~~remove~~removing external catheters, inspect skin, and reapplication of same;

(iii) ~~administer~~administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas (~~Pre~~pre-packaged only) ~~with members~~ without contraindicating rectal or intestinal conditions;

(iv) ~~apply~~applying medicated (prescription) lotions or ointments~~,~~ and dry, non-sterile dressings to unbroken skin;

(v) ~~use~~using a lift for transfers;

(vi) manually ~~assist~~assisting with oral medications;

(vii) ~~provide~~providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the service plan ~~of care,~~ unless contraindicated by underlying joint pathology;

(viii) ~~apply~~applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) ~~use Universal~~using universal precautions as defined by the ~~Center~~Centers for Disease Control and Prevention.

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

(i) processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

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

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

(iv) ~~providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with~~

~~Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant~~ providing orientation and training regarding employer responsibilities, as well employer information and management guidelines, materials, tools and staff consultant expertise to support and assist the member in successfully performing employer-related functions; and

(v) ~~for~~ making ~~available~~ Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

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

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

(17) **~~Institution Transition Services~~Institutional transition services.**

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

(B) ~~Institution Transition Case Management Services~~Transitional case management services are services ~~as described in~~per OAC 317:30-5-763(1) required by the ~~individual's plan of care~~member and included on the member's service plan~~, which~~that are necessary to ensure the health, welfare, and safety of the ~~individual~~member, or to enable the ~~individual~~member to function with greater independence in the home, and without which, the ~~individual~~member would continue to require institutionalization. ADvantage ~~Transition Case Management Services~~transitional case management services assist institutionalized ~~individuals~~members ~~that~~who are eligible to receive ADvantage services in gaining access to needed ~~waiver~~Waiver and other State plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the

funding source for the services to which access is gained. ~~TransitionCase Management Services~~Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay~~,~~ and for assisting the member transition from institution to home by updating the service plan, including necessary ~~Institution Transition Services~~institutional transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. ~~Transition Case Management Services~~Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but ~~have been~~were referred by ~~the OKDHS/ASD~~ DHS AS to the ~~Case Management Provider~~case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

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

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

(C) Institutional ~~Transition Services~~transition services may be authorized and reimbursed ~~under the following~~per the conditions in (i) through (iv)~~:~~.

(i) The service is necessary to enable the ~~individual~~member to move from the institution to ~~their~~his or her home~~;~~.

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

(iii) Institutional ~~Transition Services~~transition services are provided to the ~~individual~~member within 180 calendar-days of discharge from the institution~~;~~.

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

(D) ~~If~~When the member ~~hasreceived~~receives ~~Institution Transition Services~~institutional transition services but fails to enter the ~~waiver~~Waiver, any ~~Institution Transition Services~~institutional transition services provided are not reimbursable.

(18) **Assisted ~~Living Services~~living services.**

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

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

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

(i) ADvantage-certified ~~Assisted Living Centers~~assisted living centers (~~ALCs~~ ALC) are required to accept all

eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one or more of the following:

(I) rental unit availability;

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

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

(IV) restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage ~~participants~~members. The number of rental units available to service the ADvantage participants may be altered based upon written request from the provider and acceptance by the ADvantage Administration (AA).

(iii) Mild or moderate, cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate ~~individuals~~members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage ~~Case Manager~~case manager, the member, ~~and/~~or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, ~~and~~ dignity, respect, and freedom from coercion and restraint. The ALC must optimize member's initiative, autonomy and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs ~~will~~ is not ~~be~~ recognized as a reason for determining ~~that~~ an ADvantage ~~participant's~~member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed ~~in the description of assisted living center services~~ in the Oklahoma State Department of Health regulations (OAC 310:663-3-3), except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the ~~following~~ services~~:~~listed in (I) through (III).

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

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to ~~members'~~the member's needs and choices; and provide members with 24-hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for ~~residents~~members with Alzheimer's disease and related dementias, physical disabilities, or other special needs ~~that~~ the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, will be utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

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

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

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

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

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

(II) The member exhibits behavior or actions that repeatedly and substantially ~~interferes~~interfere with the rights or well-being of other residents and the ALC has documented efforts to resolve behavior problems including medical ~~interventions~~, behavioral, ~~interventions~~ and increased staffing interventions. Documentation must support ~~that~~the ALC attempted interventions to resolve behavior problems~~;~~.

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

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

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ~~assisted living center~~ALC must inform the member and~~/or~~ the member's representative, if any, the AA and the member's ADvantage ~~Case Manager~~case manager. The ALC must develop a discharge plan in consultation with the member, the member's ~~support network~~representative, the ADvantage ~~Case Manager~~case manager, and the AA. The ALC

and ~~Case Manager~~case manager must ensure ~~that~~ the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members ~~awaiting a move~~transitioning out of the ALC, ~~if~~when the reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage ~~Case Manager~~case manager and the AA, giving the member 30 calendar-days, written notice of the ALC's intent to terminate the residency agreement and move the member to ~~a more~~an appropriate care provider. The 30 calendar-day requirement ~~shall~~must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents ~~of the ALC~~. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

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

(II) the notice date ~~of the notice~~;

(III) the date notice was given to the member and the member's representative, the ADvantage Case Manager, and the AA;

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

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

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

(i) Physical environment.

(I) The ALC must provide lockable doors on the entry door of each rental unit and ~~a~~an attached, lockable compartment within each member unit for valuables. ~~Member residents~~Members must have exclusive rights to ~~their units~~his or her unit with lockable doors at the entrance of ~~their~~the individual ~~and/~~or shared rental unit ~~and to a lockable compartment within each member's rental unit for valuables, except in the case of documented contraindication.~~Keys to rooms may be held by appropriate ALC staff as designated by the member's choice. Rental units may be shared only ~~if~~when a request to do so is

initiated by the member ~~resident~~. Members must be given the right to choose his or her roommate.
(II) The member has a legally enforceable agreement (lease) with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord tenant law of the state, county, city, or other designated entity.
~~(II)~~(III) The ALC must provide each rental unit with a means for each member ~~resident~~ to control the temperature in the ~~individual living~~residential unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the ~~resident~~member and that preserves ~~resident~~ privacy, independence, and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.
~~(III)~~(IV) For ~~ALCS~~ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, ~~(~~including closets and storage ~~area)~~areas, of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, ~~(~~including closets and storage ~~area)~~areas, of 360 square feet.
~~(IV)~~(V) The ALC ~~shall~~must provide a private bathroom for each living unit ~~which~~that must be equipped with one lavatory, one toilet, and one bathtub or shower stall.
~~(V)~~(VI) The ALC must provide at a minimum, a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance, ~~(~~a microwave is acceptable~~),~~. ~~and adequate storage space for utensils.~~
~~(VI)~~(VII) The member is responsible for furnishing ~~their~~ the rental unit. If a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if ~~the~~ member supplied furnishings pose a health or safety risk, the member's ~~Case Manager~~ADvantage case manager in coordination with the ALC must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

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

~~(VIII)~~(IX) The ALC must ensure the design of common areas accommodates the special needs of ~~their~~the resident population and that the rental unit accommodates the special needs of the ~~individual~~member in compliance with ~~ADA Accessibility Guidelines~~the Americans with Disabilities Act accessibility guidelines per ~~(~~28 ~~CFR~~Code of Federal Regulations, Part 36, Appendix A~~)~~, at no additional cost to the member.

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

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

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed, but may be limited by the ALC to the extent to which a visitor may stay overnight.

~~(XII)~~(XIII) The ALC must be physically accessible to members.

(ii) Sanitation.

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

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

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

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

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

(iii) Health and Safety.

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

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

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

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

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

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

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

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

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

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

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

(iv) Staff to resident ratios.

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

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

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

(v) Staff training and qualifications.

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

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

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

(vi) Staff supervision.

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

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

(vii) Resident rights.

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

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

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

(viii) Incident reporting.

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage ~~Case Manager~~case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also to be made to Adult Protective Services (APS) and to the Oklahoma State Department of Health (OSDH), as appropriate, in accordance with the ALC's licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ~~Assisted Living Centers~~ALC are those defined by ~~the Oklahoma State Department of Health (~~OSDH~~) in~~per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting Form.

(III) Reports of incidents must be made to the member's ADvantage ~~Case Manager~~case manager and to the AA via facsimile or mail within one business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. If required, a follow-up report of the incident must ~~will~~ be submitted via facsimile or mail to the member's ADvantage ~~Case Manager~~case manager and to the AA.~~,~~ The follow up report must be submitted within five business days ~~after~~ of the incident. The final report must be filed with the member's ADvantage ~~Case Manager~~case manager and ~~to~~ the ~~ADvantage Administration~~AA when the ~~full~~ investigation is complete, not to exceed ~~ten~~10 business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either ~~the Oklahoma Department of Human Services , the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred~~,DHS Adult Protective Services (APS) ~~or the local municipal police department or sheriff's department~~ as soon as the person is aware of the situation~~, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes~~perO.S. 43A § 10-104.A. Reports ~~should~~are also ~~be~~ made to ~~the~~ OSDH, as appropriate, ~~in accordance with the ALC's~~per ALC licensure rules.

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

(ix) Provision of or arrangement for necessary health services.

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

(II) The ALC must provide or coordinate with the member and the member's ADvantage ~~Case Manager~~case manager for delivery of necessary health services. The ADvantage ~~Case Manager~~case manager is responsible for monitoring ~~that~~ all health-related services required by the member as identified through assessment and documented on the service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ~~Assisted Living Services~~ALS are billed per diem of service for days covered by the ADvantage member's service plan and during which the ~~Assisted Living Services~~ALS provider is responsible for providing ~~Assisted Living servicedas needed by~~ALSfor the member. The per diem rate for ~~the~~ ADvantage assisted living services for a member ~~will be~~is one of three per diem rate levels based ~~upon individual~~on a member's need for ~~service-~~type of, intensity of, and frequency of service to address member ~~ADL/IADL~~ADLs, IADLs, and health care needs. The rate level is based ~~upon~~ on the Universal Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage ~~Case Manager~~case manager employed by a ~~Case Management~~case management agency ~~that is~~ independent of the ~~Assisted Living Services~~ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

Submitted to the C.E.O. and Board on December 10, 2015

AUTHORITY FOR EXPENDITURE OF FUNDS
Insure Oklahoma Multimedia Marketing
Staplegun Design, Inc.

BACKGROUND

OHCA released a Request for Proposal (RFP) for the services of a vendor to develop and implement a multimedia marketing campaign to promote Insure Oklahoma throughout the entire State of Oklahoma.

This RFP was awarded to Staplegun Design Inc. with Contract Term April 16, 2015 thru December 31, 2015. Two additional options to renew were designated within the final contract as: 01/01/2016 - 12/31/2016 and 01/01/2016 – 12/31/2017.

SCOPE OF WORK

- Continued editing and production of current and other advertising collateral to reflect program changes as needed;
- Continued negotiation and purchase of media buys within allotted budget pertaining to developed campaign strategy targeting employer-sponsored insurance audience;

CONTRACT PERIOD

The original contract term of this Agreement began April 16, 2015 and will end December 31, 2017. A purchase order was issued for the first agreement period and a change order to the original purchase order will be issued to the Contractor at the beginning of the following agreement period.

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Awarded through competitive bidding conducted by OHCA
- Anticipated federal matching percentage is 50%
- No appropriated dollars are involved as state share is funded by tobacco tax dollars.
- Not to exceed contract amount for calendar year 2016: $450,000/year

RECOMMENDATION

- Board approval to expend funds for the services discussed above.

PROPOSED OHCA BOARD MEETINGS/LOCATIONS - 2016

JANUARY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	**14**	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	**11**	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29					

MARCH

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	**24**	25	26
27	28	29	30	31		

APRIL

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	**12**	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	**30**		

January 14, 2016 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

February 11, 2016 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

March 24, 2016 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

May 12, 2016 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

June 30, 2016 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

August 10, 2016 • Board Meeting • 1:00 pm
August 10, 2015 • SPC • 2:30 pm
August SPC • 11 & 12, 2015 • 8:30 am
TBD

September 8, 2016 • 1:00 pm
Lawton
Location TBD

October 13, 2016 • 1:00 pm
Duncan
Location TBD

November 10, 2016 • 1:00 pm
Enid
Location TBD

December 8, 2016 • 1:00 pm
Tulsa
Location TBD

JULY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	**10**	**11**	**12**	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	**8**	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	**13**	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	**10**	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	**8**	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

*Dates in Red are Proposed Board Dates