MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
May 17, 2012
1:00 p.m. – Ponca Conference Room
2401 NW 23rd St., Suite 1A
Oklahoma City, OK 73107

I. Welcome, Roll Call, and Public Comment Instructions

II. Approval of minutes of the March 7, 2012 Medical Advisory Committee Meeting

III. MAC Member Comments/Discussion

IV. Legislative Update: Nico Gomez, Deputy Chief Executive Officer

V. Behavioral Health and IT Consolidation: Mike Fogarty, Chief Executive Officer

VI. Financial Report: Gloria Hudson, Director of General Accounting
   A. March Financial Summary
   B. March Financial Detail Report

VII. SoonerCare Operations Update: Melody Anthony, Provider Services Director, and Chad Sickler, Health Information Technology Program Coordinator
   A. SoonerCare Programs Report
   B. May Health Access Network (HAN) Summary
   C. Electronic Health Record (EHR) Incentive Program Highlights

VIII. Action Items:

OKDHS Initiated

12-01 Homeward Bound Waiver HTS Providers
Emergency rule revisions are proposed to provide an exception for members of the Homeward Bound Waiver receiving Habilitation Training Specialist (HTS) services. The rule revision will allow the HTS to provide more than 40 hours of service per week, when the HTS resides in the same home as the member. The rule revision is promulgated as the result of a lawsuit filed on behalf of class members of the Homeward Bound waiver.
Budget Impact – Budget Neutral

IX. New Business

X. Adjourn

Next Meeting: Thursday, July 19, 2012.

DRAFT

MEDICAL ADVISORY COMMITTEE MEETING
Draft Meeting Minutes
March 7, 2012

Members attending: Dr. Bourdeau, Ms. Brinkley, Ms. Case, Dr. Cavallaro, Dr. Crawford, Mr. Rick Snyder, Ms. Karen Bradford, Mr. Goforth, Dr. Grogg, Ms. Holiman-James, Mr. Jones, Mr. McAdoo, Dr. McCrory, Dr. McNeill, Dr. Ogle, Mr. Pilgrim, Dr. Post, Dr. Rhoades, Dr. Rhynes, Ms. Russell, Ms. Mays, Dr. Simon, Ms. Slatton-Hodges, Ms. Stockton, Mr. Tallent

Members absent: Ms. Bates, Ms. Bellah, Ms. Felty, Ms. Fritz, Dr. Wells, Dr. Woodward, Dr. Wright

I. Welcome, Roll Call, and Public Comment Instructions

Dr. Crawford welcomed the committee members and called the meeting to order. Roll call established the presence of a quorum. There were no requests for public comment.

II. Approval of minutes of the January 19, 2012 Medical Advisory Committee Meeting

Dr. Cavallaro moved to approve the minutes as presented. Dr. McNeill seconded. Approved.

III. MAC Member Comments/Discussion

Dr. Simon thanked the SoonerRide staff for their assistance since the last meeting regarding exceptions to 1 person accompanying a member. Dr. Simon said this has been very helpful to many families.

Dr. Simon also discussed circumcisions, and the hope that this benefit will not be dropped. Dr. Keenan said it has been discussed with physicians internally and the MAT, and they are of the opinion there is good reason for it. HIV is not as much an issue as in other countries. We are not inclined to do anything different.

Dr. Crawford mentioned Pam Cross' 4th "Super Saturdays for Women", a program for breast and cervical cancer screenings, which has been successful. This is put on by Good Shepherd Ministries, and Dr. McNeill is their medical director.

Dr. Grogg commended Dr. Simon on the fantastic AAP write-up Dr. Simon spoke of regarding the MAC. This article will be sent to the MAC members.

Dr. Cavallaro was acknowledged for his recent mission work in Honduras.

IV. **Legislative Update:** Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez reviewed the House and Senate bills on the handout. SB1161, HB2273, HB2270 and SB1629 are items to watch. The Governor has reviewed her SFY '13 budget, and included a 1% budget reduction for OHCA, a $9.8 million. It took some of the hospital fee (Supplemental Hospital Offset Provider Payment - SHOPP bill) funding to replace the one-time stimulus fund, $30 million. The Governor's budget also transferred behavioral health policy setting responsibility and State matching dollars to the Department of Mental Health and Substance Abuse Services (DMHSAS), $136 million. This is where we start. The Legislature finished their work on the supplemental budget, they appropriated $92.5 million to deal with some issues in the current fiscal year as it relates to education, highway patrol, Medical Examiner's Office. Once they finish their supplemental budget, they work on their SFY '13 budget, and we expect the House and Senate to start having their meetings with the Governor's office to start to address the issues in her budget, as well as their budget priorities, and to hammer out any final budget, expected in May. Please refer to the handout for more detailed information on the bills this legislative session.

V. Financial Report: Gloria Hudson, Director of General Accounting

A. December Financial Summary
B. December Financial Detail Report
C. Supplemental Hospital Offset Provider Payment (SHOPP)

Ms. Hudson reviewed the handouts. There were no questions.

VI. SoonerCare Operations Update:

A. SoonerCare Programs Report – Shelly Patterson, Marlene Asmussen and Rebekah Gossett - Child Health, Care Management and MAU
B. Hardware Cutover – Jerry Scherer, Director of Information Services
C. Durable Medical Equipment – Stan Ruffner, DME Program Director

The presenters reviewed the handouts on prenatal, tobacco cessation and infant mortality.

Dr. Grogg complimented the SoonerQuit, tobacco cessation program.

Regarding the infant mortality handout, Ms. Gossett reports the education has received favorable feedback from our members. Over 82% of women identified have remained in active case management, and 96% of the babies. Some have passed, others are adopted out. Ms. Gossett said hospital support for the mothers is great, but when they get home, it's a whole new reality, and that's when they get back with the case managers. We are on the right track.

Ms. Case asked - How does this tie to methamphetamine use? Ms. Gossett replied that we do see drug abuse in certain areas, and have referred some women to inpatient-safe homes. They stay there until they deliver. Some know they will not be able to take care of their baby and on their own elected to adopt out. The Care Management staff continues to monitor the mother from pregnancy until the child turns one year of age.

Clarification to the 26.8% mortality rate on the handout. It should be 26.8 persons per thousand, not percentage. The MAC suggested looking at a decade of time and comparing rates over those 10 years.

Dr. Crawford commented that the presentation is remarkable and the MAC appreciates the work of the State Health Department and the OHCA working together.

Mr. Scherer reviewed the handout regarding the hardware cutover and the upgrade to the computer system, There were some problems at first, which were resolved, and communication with providers is addressed on a timely basis. Dr. Rhynes asked if this was why they could not verify eligibility last week. It was. Dr. Rhynes asked, if they cannot verify a patient, are they stuck if they find that after seeing them the patient is not a SoonerCare member? Dr. Keenan replied if they are not eligible the physician can bill the family, but would not be reimbursed by SoonerCare. There were no more questions.

If the exchange is going to use Insure Oklahoma as a structure, a lot of what makes Insure Oklahoma the excellent organization that it is, is it IT? How would that work? Mr. Fogarty replied that the joint committee, Senator Stanislowski and that team, determined the kind of IT support and infrastructure that is alive and well today and Insure Oklahoma is something that could be converted and used as a platform to build a network. The infrastructure is there, the question is time.

Durable Medical Equipment – Mr. Ruffner said the OKDMERP (Oklahoma Durable Medical Equipment Reuse Program) is operational, and they moved into their location today. We anticipate the website to be up and running for our review Friday.

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Pick-up and delivery are limited to Oklahoma County, but donations are accepted from all over. The donor can bring it to the facility. We met with our DME association/advisory council and they made the suggestion internally that they are going to donate nebulizers. We will continue to work with them on that. The contact person is Katherine Woodward. There is an application process.

For more detailed descriptions, please refer to the packet.

VII. Action Items: Melinda Jones, Waiver Administration and Development Director

Ms. Jones updated the MAC regarding DME Rules for intermittent catheters. This will not go to Board tomorrow. We have had some additional review and discussion from advocates, and at this time we have decided to step back and work on it together, and bring forward a better product in the future.

Ms. Jones also discussed 1915(c) waivers. These help provide home and community-based services for our SoonerCare members. These are alternatives to institutional long term care. Waivers have been around since the 80s. Our partnership with the Department of Human Services, in the Developmental Disabilities Services Division operate two programs called “In Home Supports”, one for adults, one for children. Those programs are pending a renewal cycle, by the end of March, we need to submit the new renewal application for those waivers. Further information is on the handout.

<u>OHCA Initiated</u>

11-21 Living Choice Re-enrollment
OHCA rules for the Living Choice demonstration program are revised to clarify that individuals residing in a nursing facility or ICF/MR in lieu of incarceration are not eligible for the Living Choice program. Rules are also revised to add that Living Choice members who have completed their full 365 days of eligibility and are re-institutionalized for 90 consecutive days are eligible to re-apply for an additional 365 days of service.
Budget Impact – Federal $112,908; State $14,866

<u>OKDHS Initiated</u>

11-39 ADvantage Waiver Annual Clean-up Revisions
OHCA rules for the ADvantage Waiver are revised to remove language requiring transportation services to be provided by Adult Day Health Centers, provide clarification of family support services versus waiver services, add language clarifying "client support moderate risk", "client support high risk" and addition of language describing "client support low risk" and "environmental low risk". Policy is also revised to add eligibility language clarifying member reauthorization, recertification and redetermination, clarification regarding the member's level of need in order to be eligible for waiver services, clarification about the types of living arrangements allowable for ADvantage members, and clarification regarding the member's health, safety and welfare. Additionally, policy is revised to remove language allowing a financial eligibility assessment for individuals who are not applying for waiver services, add clarification regarding when a new level of care determination is required, removal of language requiring recertification of the member by a case manager and requiring an OKDHS nurse to provide medical certification at a minimum, annually. Lastly, changes include the addition of language regarding plan of care documentation when more than one member of a household receives waiver services, clarification regarding the use of family members as paid providers, clarification of conditions requiring a member's service plan goals, the removal of policy regarding the expedited eligibility determination process (SPEED) and other minor clean-up revisions.
Budget Impact – Budget Neutral

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There were no questions. Ms. Holiman-James moved to approve. Dr. Cavallaro seconded. Approved en bloc.

VIII. New Business

No new business.

IX. Adjourn 2:58 p.m.

Next Meeting: Thursday, May 17, 2012.

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OHCA MAC MEETING

MAY 17, 2012 OHCA MEDICAL ADVISORY COMMITTEE MEETING

OHCA REQUEST BILLS:

- HB 2273 – Rep. Doug Cox – Allows OHCA to pay for professional expenses for OHCA CEO and Physicians; Permits Prior Authorizations for Hepatitis C and HIV prescriptions; **GCCA Committee – Failed – Lack of signatures on 5-9-12.**
- SB 1161 – Sen. Gary Stanislawski – Authorizes OHCA to employ one Program Integrity auditor for every $100,000,000 expended in state and federal funds if the return on investment, including cost avoidance, is greater than the total direct and indirect costs of the employee. Program integrity auditors shall not count toward any full-time equivalent limitations on the agency. **Failed Deadline 2-20-12.**

After the April 26th deadline for Third Reading of Bills in the Opposite Chamber and as of noon Wednesday, May 9th, 2012, the Oklahoma Legislature is tracking a total of 806 active bills. OHCA is currently tracking 72 bills. They are broken down as follows:

- OHCA Request 01
- Direct Impact 19
- Agency Interest 08
- Employee Interest 04
- OHCA Appropriations 03
- Governor Signed/Vetoed 07
- 2011 Carryover 30

May 25, 2012 Sine Die Adjournment of the Second Session of the 53rd Legislature

A Legislative Bill Tracking Report will be included in your handout at the MAC Meeting.

FINANCIAL REPORT

For the Nine Months Ended March 31, 2012
Submitted to the CEO & Board
April 12, 2012

- Revenues for OHCA through March, accounting for receivables, were **$2,812,476,497** or **(.2%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,639,258,072** or **1.5% under** budget.
- The state dollar budget variance through March is **$33,428,729 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		15.2
Administration		5.3
Revenues:		
Taxes and Fees		4.1
Drug Rebate		4.8
Overpayments/Settlements		4.0
Total FY 12 Variance	**$**	**33.4**

ATTACHMENTS

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

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

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 700,385,299	$ 700,385,299	$ -	0.0%
Federal Funds	1,635,852,060	1,600,983,756	(34,868,304)	(2.1)%
Tobacco Tax Collections	41,029,075	44,747,494	3,718,419	9.1%
Quality of Care Collections	38,232,627	38,660,068	427,441	1.1%
Prior Year Carryover	55,003,490	55,003,490	-	0.0%
Federal Deferral - Interest	284,824	284,824	-	0.0%
Drug Rebates	117,433,807	130,731,113	13,297,306	11.3%
Medical Refunds	30,263,155	40,979,395	10,716,240	35.4%
SHOPP	187,240,570	187,240,570	-	0.0%
Other Revenues	13,013,524	13,460,488	446,964	3.4%
TOTAL REVENUES	**$ 2,818,738,431**	**$ 2,812,476,497**	**$ (6,261,934)**	**(0.2)%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 32,756,920**	**$ 28,952,983**	**$ 3,803,937**	**11.6%**
ADMINISTRATION - CONTRACTS	**$ 87,944,179**	**$ 78,561,681**	**$ 9,382,498**	**10.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	24,145,134	22,984,651	1,160,483	4.8%
Acute Fee for Service Payments:				
Hospital Services	687,943,963	662,688,726	25,255,237	3.7%
Behavioral Health	236,451,881	252,828,609	(16,376,729)	(6.9)%
Physicians	336,107,634	332,905,730	3,201,904	1.0%
Dentists	109,029,799	108,796,280	233,519	0.2%
Other Practitioners	55,331,217	53,659,926	1,671,290	3.0%
Home Health Care	16,764,428	15,754,739	1,009,689	6.0%
Lab & Radiology	41,025,186	39,416,576	1,608,610	3.9%
Medical Supplies	36,649,965	36,603,812	46,154	0.1%
Ambulatory Clinics	66,865,978	61,525,387	5,340,591	8.0%
Prescription Drugs	284,060,356	289,096,528	(5,036,171)	(1.8)%
Miscellaneous Medical Payments	24,695,149	25,127,318	(432,169)	(1.8)%
OHCA TFC	-	-	-	0.0%
Other Payments:				
Nursing Facilities	367,310,358	367,244,720	65,638	0.0%
ICF-MR Private	44,280,660	42,594,837	1,685,823	3.8%
Medicare Buy-In	110,597,918	104,202,246	6,395,672	5.8%
Transportation	21,106,443	20,748,252	358,191	1.7%
EHR-Incentive Payments	39,717,795	39,717,795	-	0.0%
Part D Phase-In Contribution	56,074,389	55,847,276	227,113	0.4%
Total OHCA Medical Programs	**2,558,158,253**	**2,531,743,408**	**26,414,845**	**1.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,678,948,734**	**$ 2,639,258,072**	**$ 39,690,662**	**1.5%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 139,789,696**	**$ 173,218,425**	**$ 33,428,729**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2012, For the Nine Months Ended March 31, 2012

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 23,326,159	$ 22,968,586	$ -	$ 341,508	$ -	$ 16,065	$ -
Inpatient Acute Care	556,425,375	436,530,527	365,015	9,404,948	37,736,720	2,186,709	70,201,457
Outpatient Acute Care	193,815,182	181,964,266	31,203	7,945,426	-	3,874,287	
Behavioral Health - Inpatient	86,783,593	84,433,844	-	-	-	2,658	2,347,091
Behavioral Health - Outpatient	22,301,446	22,291,924	-	-	-	-	9,522
Behavioral Health Facility- Rehab	164,708,121	143,492,993	-	385,756	-	92,174	20,737,198
Behavioral Health - Case Management	-	-	-	-	-	-	
Residential Behavioral Management	14,102,969	-	-	-	-	-	14,102,969
Targeted Case Management	45,806,309	-	-	-	-	-	45,806,309
Therapeutic Foster Care	2,515,016	2,515,016	-	-	-	-	-
Physicians	372,040,110	279,709,773	43,576	11,391,536	45,989,902	7,162,479	27,742,845
Dentists	108,897,488	102,747,874	-	101,208	5,985,579	62,827	-
Other Practitioners	54,037,832	52,569,890	334,773	377,906	733,753	21,510	-
Home Health Care	15,754,747	15,719,138	-	7	-	35,601	-
Lab & Radiology	41,824,521	38,464,615	-	2,407,945	-	951,961	-
Medical Supplies	37,162,228	34,691,952	1,856,962	558,416	-	54,898	-
Ambulatory Clinics	71,888,707	61,246,872	-	1,387,997	-	278,515	8,975,324
Personal Care Services	9,384,772	-	-	-	-	-	9,384,772
Nursing Facilities	367,244,720	234,898,829	102,347,196	-	29,982,043	16,652	-
Transportation	20,748,252	18,743,658	1,948,843		51,287	4,464	-
GME/IME/DME	88,507,821	-	-	-	-	-	88,507,821
ICF/MR Private	42,594,837	35,011,383	6,946,786	-	636,667	-	-
ICF/MR Public	42,510,019	-	-	-	-	-	42,510,019
CMS Payments	160,049,522	158,111,411	1,938,111	-	-	-	-
Prescription Drugs	303,220,033	255,400,007	-	14,123,506	32,263,421	1,433,099	-
Miscellaneous Medical Payments	25,127,652	24,000,149	-	334	1,067,626	59,543	-
Home and Community Based Waiver	117,623,711	-	-	-	-	-	117,623,711
Homeward Bound Waiver	65,752,494	-	-	-	-	-	65,752,494
Money Follows the Person	2,415,913	-	-	-	-	-	2,415,913
In-Home Support Waiver	17,783,407	-	-	-	-	-	17,783,407
ADvantage Waiver	130,237,571	-	-	-	-	-	130,237,571
Family Planning/Family Planning Waiver	5,854,136	-	-	-	-	-	5,854,136
Premium Assistance*	42,919,189	-	-	42,919,189	-	-	-
EHR Incentive Payments	39,717,795	39,717,795					
Total Medicaid Expenditures	**$ 3,293,081,651**	**$2,245,230,502**	**$ 115,812,465**	**$ 91,345,682**	**$ 154,446,998**	**$ 16,253,443**	**$ 669,992,561**

* Includes $42,626,529.77 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2012, For the Nine Months Ended March 31, 2012

REVENUE		FY12 Actual YTD
Revenues from Other State Agencies	$	271,673,166
Federal Funds		432,468,970
TOTAL REVENUES	**$**	**704,142,135**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	117,623,711
Money Follows the Person		2,415,913
Homeward Bound Waiver		65,752,494
In-Home Support Waivers		17,783,407
ADvantage Waiver		130,237,571
ICF/MR Public		42,510,019
Personal Care		9,384,772
Residential Behavioral Management		10,531,061
Targeted Case Management		32,623,411
Total Department of Human Services		**428,862,360**
State Employees Physician Payment		
Physician Payments		27,742,845
Total State Employees Physician Payment		**27,742,845**
Education Payments		
Graduate Medical Education		42,900,000
Graduate Medical Education - PMTC		4,052,001
Indirect Medical Education		29,677,651
Direct Medical Education		11,878,169
Total Education Payments		**88,507,821**
Office of Juvenile Affairs		
Targeted Case Management		2,421,571
Residential Behavioral Management - Foster Care		23,814
Residential Behavioral Management		3,548,095
Multi-Systemic Therapy		9,522
Total Office of Juvenile Affairs		**6,003,002**
Department of Mental Health		
Targeted Case Management		-
Hospital		2,347,091
Mental Health Clinics		20,737,198
Total Department of Mental Health		**23,084,290**
State Department of Health		
Children's First		1,576,541
Sooner Start		1,770,921
Early Intervention		4,767,225
EPSDT Clinic		1,731,401
Family Planning		56,425
Family Planning Waiver		5,757,907
Maternity Clinic		69,990
Total Department of Health		**15,730,409**
County Health Departments		
EPSDT Clinic		604,160
Family Planning Waiver		39,805
Total County Health Departments		**643,965**
State Department of Education		**99,043**
Public Schools		**4,318,518**
Medicare DRG Limit		**64,133,658**
Native American Tribal Agreements		**4,798,852**
Department of Corrections		**615,879**
JD McCarty		**5,451,919**
Total OSA Medicaid Programs	**$**	**669,992,561**
OSA Non-Medicaid Programs	**$**	**60,978,470**
Accounts Receivable from OSA	**$**	**26,828,895**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

Fiscal Year 2012, For the Nine Months Ended March 31, 2012

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 38,632,106**	**$ 38,632,106**
Interest Earned	**27,962**	**27,962**
TOTAL REVENUES	**$ 38,660,068**	**$ 38,660,068**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 99,507,140	$ 35,673,310	
Eyeglasses and Dentures	217,076	77,822	
Personal Allowance Increase	2,622,980	940,338	
Coverage for DME and supplies	1,856,962	665,721	
Coverage of QMB's	774,567	277,682	
Part D Phase-In	1,938,111	1,938,111	
ICF/MR Rate Adjustment	3,686,913	1,321,758	
Acute/MR Adjustments	3,259,874	1,168,665	
NET - Soonerride	1,948,843	698,660	
Total Program Costs	**$ 115,812,465**	**$ 42,762,067**	**$ 42,762,067**
Administration			
OHCA Administration Costs	$ 413,997	$ 206,998	
DHS - 10 Regional Ombudsman	78,819	78,819	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	10,000	5,000	
Total Administration Costs	**$ 502,816**	**$ 290,817**	**$ 290,817**
Total Quality of Care Fee Costs	**$ 116,315,280**	**$ 43,052,884**	
TOTAL STATE SHARE OF COSTS			**$ 43,052,884**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
Fiscal Year 2012, For the Nine Months Ended March 31, 2012

REVENUES	FY 11 Carryover	FY 12 Revenue	Total Revenue
Prior Year Balance	$ 17,037,771	$ -	$ 13,845,668
State Appropriations			
Tobacco Tax Collections	-	36,803,362	36,803,362
Interest Income	-	421,069	421,069
Federal Draws	4,432,268	27,438,694	27,438,694
All Kids Act	(7,325,312)	217,319	217,319
TOTAL REVENUES	**$ 14,144,727**	**$ 64,880,445**	**$ 78,508,793**

EXPENDITURES		FY 11 Expenditures	FY 12 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 42,120,666	$ 42,120,666
	College Students		267,659	267,659
	All Kids Act		505,864	505,864
Individual Plan				
	SoonerCare Choice		$ 331,725	$ 118,923
	Inpatient Hospital		9,376,163	3,361,355
	Outpatient Hospital		7,850,587	2,814,435
	BH - Inpatient Services		-	-
	BH Facility - Rehabilitation Services		382,024	136,956
	Physicians		11,291,236	4,047,908
	Dentists		88,572	31,753
	Other Practitioners		369,499	132,466
	Home Health		7	3
	Lab and Radiology		2,375,344	851,561
	Medical Supplies		550,070	197,200
	Ambulatory Clinics		1,372,470	492,031
	Prescription Drugs		13,940,524	4,997,678
	Miscellaneous Medical		25,000	25,000
	Premiums Collected		-	(1,814,050)
Total Individual Plan			**$ 47,953,223**	**$ 15,393,218**
	College Students-Service Costs		**$ 397,944**	**$ 142,663**
	All Kids Act- Service Costs		**$ 100,327**	**$ 35,967**
Total Program Costs			**$ 91,345,682**	**$ 58,466,037**
Administrative Costs				
	Salaries	$ 13,534	$ 1,197,735	$ 1,211,269
	Operating Costs	29,081	91,843	120,924
	Health Dept-Postponing	-	-	-
	Contract - HP	256,445	1,512,841	1,769,285
Total Administrative Costs		**$ 299,059**	**$ 2,802,418**	**$ 3,101,478**
Total Expenditures				**$ 61,567,515**
NET CASH BALANCE		**$ 13,845,668**		**$ 16,941,279**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2012, For the Nine Months Ended March 31, 2012

REVENUES	FY 12 Revenue	State Share
Tobacco Tax Collections	**$ 734,491**	**$ 734,491**
TOTAL REVENUES	**$ 734,491**	**$ 734,491**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 16,065	$ 4,032	
Inpatient Hospital	2,186,709	548,864	
Outpatient Hospital	3,874,287	972,446	
Inpatient Free Standing	2,658	667	
MH Facility Rehab	92,174	23,136	
Case Mangement	0	-	
Nursing Facility	16,652	4,180	
Physicians	7,162,479	1,797,782	
Dentists	62,827	15,769	
Other Practitioners	21,510	5,399	
Home Health	35,601	8,936	
Lab & Radiology	951,961	238,942	
Medical Supplies	54,898	13,780	
Ambulatory Clinics	278,515	69,907	
Prescription Drugs	1,433,099	359,708	
Transportation	4,464	1,120	
Miscellaneous Medical	59,543	14,945	
Total Program Costs	$ 16,253,443	$ 4,079,614	**$ 4,079,614**
TOTAL STATE SHARE OF COSTS			**$ 4,079,614**

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

SoonerCare Programs

March 2012 Data for May 2012 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2011	Enrollment March 2012	Total Expenditures March 2012	Average Dollars Per Member Per Month March 2012
SoonerCare Choice Patient-Centered Medical Home		449,392	**483,976**	**$143,706,612**	
	Lower Cost *(Children/Parents; Other)*		439,276	$104,792,465	$239
	Higher Cost *(Aged, Blind or Disabled; TEFRA; BCC)*		44,700	$38,914,148	$871
SoonerCare Traditional		239,274	**237,282**	**$173,149,717**	
	Lower Cost *(Children/Parents; Other)*		129,481	$46,063,850	$356
	Higher Cost *(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,801	$127,085,867	$1,179
SoonerPlan		31,082	**42,973**	**$782,476**	$18
Insure Oklahoma		32,181	**31,138**	**$10,040,223**	
	Employer-Sponsored Insurance	19,095	17,564	$4,650,988	$265
	Individual Plan	13,085	13,574	$5,389,235	$397
TOTAL		**751,928**	**795,369**	**$327,679,028**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $218,565,586 are excluded.

Net Enrollee Count Change from Previous Month Total	3,418

New Enrollees	19,503

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,394
Aged/Blind/Disabled	*Adult*	131,504
Other	*Child*	191
Other	*Adult*	20,647
PACE	*Adult*	98
TEFRA	*Child*	432
Living Choice	*Adult*	98
OLL Enrollment		**172,364**

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

Medicare and SoonerCare	Monthly Average SFY2011	Enrolled March 2012
Dual Enrollees	**103,906**	**108,312**

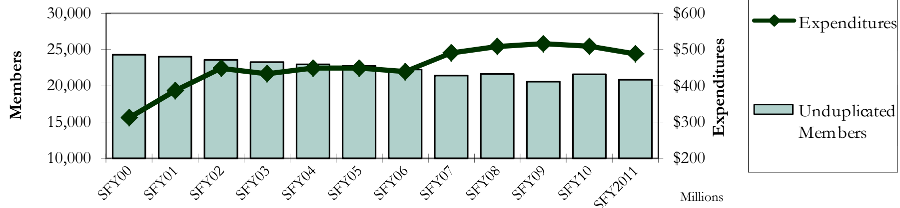
		Monthly Average SFY2011	Enrolled March 2012	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,731**	**$3,110**
	Child	92	80	
	Adult	15,641	15,651	

SFY2011 Long-Term Care

Statewide LTC Occupancy Rate - 71.0%
SoonerCare funded LTC Bed Days 68.2%

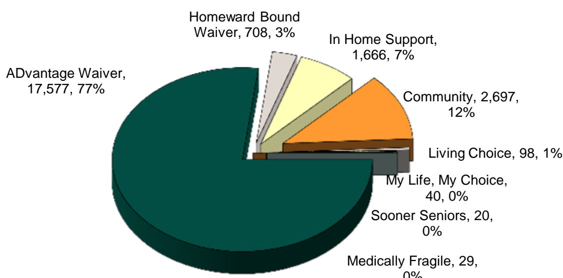
Data as of October 2011

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Aug. 8, 2011. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

Waiver Enrollment Breakdown Percent



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

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2011	Enrolled March 2012
Total Providers		**29,026**	**39,191**
	In-State	20,585	28,918
	Out-of-State	8,442	10,273

Program	% of Capacity Used
SoonerCare Choice	38%
SoonerCare Choice I/T/U	14%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled March 2012***	Total Monthly Average SFY2011	Total Enrolled March 2012
Physician	*6,489*	*7,755*	*11,777*	14,099
Pharmacy	*901*	*878*	*1,230*	1,162
Mental Health Provider***	*935*	*4,387*	*982*	4,448
Dentist	*798*	*1,013*	*901*	1,168
Hospital	*187*	*195*	*739*	980
Licensed Behavioral Health Practitioner***	*503*	*3,287*	*524*	3,311
Extended Care Facility	*392*	*367*	392	367

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

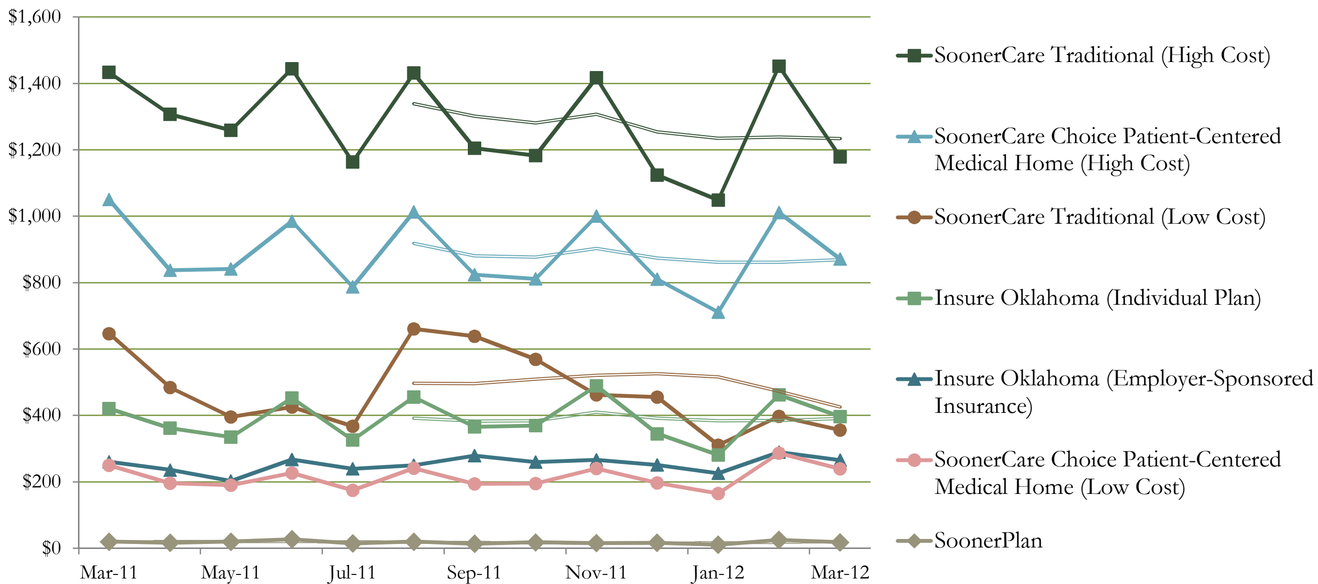
Total Primary Care Providers	*4,461*	*4,780*	6,467	6,685
Patient-Centered Medical Home	*1,476*	*1,768*	1,502	1,798

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

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

***Due to federal regulations, OHCA must have an approved agreement on file for all providers providing care to our members. To meet this requirement OHCA is directly contracting with providers that had previously billed through a group or agency. This contributed to the increase in the provider counts for Licensed Behavioral Health Practitioners and Mental Health Providers.

SOONERCARE PER MEMBER PER MONTH (PMPM) TRENDS



ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

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

As Of 5/1/2012	April 2012		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	76	$1,615,000	1,246	$26,491,667
Eligible Hospitals	0*	$0	73	$50,762,837
Totals	76	$1,615,000	1,319	$77,254,504

*Current Eligible Hospitals Paid

HAN Total Summary Report - May 2012

Provider Name	Provider ID	Total Membership	Total Number of Providers	Unduplicated Providers	PCMH Locations	High Risk OB	BCC Cases	High ER	Lock In Status	Hemophilia	Shared HMP Members
Canadian County Health Access Network	200339660A	2937	10	10	4	1	0	0	0	0	10
OSU Center for Health Sciences	200355100A	14419	126	69	7	8	4	0	0	0	87
OU Health Access Network	200298130A	38499	333	227	20	23	1	0	0	0	322
	Total:	55855	469	306	31	32	5	0	0	0	419

Provider Type Summary

Provider Name	Provider ID	09 Advance Practice Nurse	10 Mid Level Practitioner	31 Physician	52 State Employed Physician	Total Unduplicated Providers
Canadian County Health Access Network	200339660A	2	3	5	0	10
OSU Center for Health Sciences	200355100A	6	0	11	52	69
OU Health Access Network	200298130A	33	18	34	142	227
	Total:	41	21	50	194	306

HAN Q4 High ER Utilization Summary - February 15, 2012

Provider Name	Provider ID	3 ER Visits	4 to 14 ER Visits	Persistent-15 or More ER Visits	Total ER Visits
Canadian County Health Access Network	200339660A	6	2	0	8
OSU Center for Health Sciences	200355100A	104	64	0	168
OU Health Access Network	200298130A	236	155	3	394
	Total:	346	221	3	570

EHR Incentive Program Highlights

What is the Medicaid EHR Incentive Program?

- The Medicaid EHR Incentive Program provides incentive payments to eligible professionals (Physicians, Nurse Practitioners, Certified Nurse-Midwives, Dentists, and Physician Assistants*) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years.
- Eligible professionals can receive up to $63,750 over the six years that they choose to participate in the program.

2 phases of the program

- AIU – Adopt/Implement/Upgrade
- Meaningful Use (must complete 2 years of each Stage)
    - Current – Stage 1 (see Meaningful Use Stage 1 brochure)
    - CMS Proposed Rule for Stage 2
        - Finalized Summer 2012 (Effective 2014)
        - Includes changes to Stage 1 (See Table 3 attached)
- ONC Proposed Rule for CEHRT
    - Current EHR systems certified for Stage 1
    - EHR systems will need to be recertified for additional stages

Statistics (As of April 30th):

- 1,739 Eligible Professionals Registered
- 1,246 EPs Paid
- $26,491,667 Paid Out

Resources:
Oklahoma EHR Incentive Program Site:
http://www.okhca.org/ehr-incentive

EHR Incentive Program FAQs:
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html

CMS Stage 2 Proposed Rule:
http://www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4443.pdf

ONC CEHRT Proposed Rule:
http://www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4430.pdf

Eligible Hospitals and Professionals Paid EHR Incentive

Participation Percentage

- 50% to 85% (5)
- 20% to 50% (28)
- 10% to 20% (25)
- 1% to 10% (11)
- 0 (8)

- Number of EPs
- Number of EHs

County	EPs	EHs
Cimarron	0	0
Texas	3	0
Beaver	0	1
Harper	0	1
Woods	0	1
Alfalfa	4	0
Grant	0	0
Kay	10	1
Osage	9	1
Washington	14	1
Nowata	3	0
Craig	2	1
Ottawa	8	1
Ellis	0	1
Woodward	1	0
Major	0	0
Garfield	4	2
Noble	0	1
Pawnee	4	1
Tulsa	159	4
Rogers	16	0
Mayes	9	1
Delaware	16	1
Dewey	0	0
Blaine	3	1
Kingfisher	2	1
Logan	4	0
Payne	11	2
Creek	7	2
Wagoner	10	1
Cherokee	70	2
Adair	10	0
Roger Mills	0	0
Custer	11	2
Canadian	11	1
Oklahoma	503	6
Lincoln	1	1
Okmulgee	5	2
Muskogee	24	2
Okfuskee	3	0
McIntosh	5	0
Sequoyah	10	1
Beckham	7	2
Washita	0	1
Caddo	6	0
Grady	9	1
Cleveland	21	1
McClain	6	1
Pottawatomie	14	1
Seminole	8	1
Hughes	5	1
Pittsburg	12	1
Haskell	7	1
LeFlore	39	2
Latimer	1	0
Greer	1	0
Harmon	0	0
Kiowa	0	1
Jackson	7	1
Tillman	1	1
Comanche	17	3
Cotton	0	0
Stephens	13	1
Garvin	6	1
Pontotoc	36	1
Murray	0	1
Carter	2	1
Johnston	10	0
Coal	2	0
Atoka	3	1
Pushmataha	8	1
McCurtain	9	1
Jefferson	1	1
Love	0	0
Marshall	1	1
Bryan	10	1
Choctaw	5	1

Data is valid as of 5/03/2012 and is subject to change.

TABLE 3—CHANGES TO STAGE 1

Stage 1 objective	Proposed changes	Effective year (CY/FY)
Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines.	Change: Addition of an alternative measure More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	2013–Only (Optional).
Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines.	Change: Replacing the measure More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	2014–Onward (Required).
Record and chart changes in vital signs	Change: Addition of alternative age limitations More than 50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.	2013–Only (Optional).
Record and chart changes in vital signs	Change: Addition of alternative exclusions Any EP who (*1*) Sees no patients 3 years or older is excluded from recording blood pressure; (*2*) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (*3*) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (*4*) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	2013–Only (Optional).
Record and chart changes in vital signs	Change: Age Limitations on Growth Charts and Blood Pressure More than 50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.	2014–Onward (Required)
Record and chart changes in vital signs	Change: Changing the age and splitting the EP exclusion Any EP who (*1*) Sees no patients 3 years or older is excluded from recording blood pressure; (*2*) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (*3*) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (*4*) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	2014–Onward (Required).
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Change: Objective is no longer required	2013–Onward (Required).
Report ambulatory (hospital) clinical quality measures to CMS or the States.	Change: Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6.	2013–Onward (Required)
EP Objective: Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request. Hospital Objective: Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request. EP Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the EP.	Change: Replace these three objectives with the Stage 2 objective and one of the two Stage 2 measures. EP Objective: Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP. EP Measure: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. Hospital Objective: Provide patients the ability to view online, download and transmit information about a hospital admission. Hospital Measure: More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.	2014–Onward (Required).
Public Health Objectives:	Change: Addition of "except where prohibited" to the objective regulation text for the public health objectives under 42 CFR 495.6.	2013–Onward (Required).

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15). Providers of any habilitation service must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS).

(1) **Dental services.** Dental services are provided per OAC 317:40-5-112.

(A) **Minimum qualifications.** Providers of dental services must have non-restrictive licensure to practice dentistry in Oklahoma by the Board of Governors of Registered Dentists of Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) oral examination;

(ii) bite-wing x-rays;

(iii) prophylaxis;

(iv) topical fluoride treatment;

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

(I) elimination of pain;

(II) adequate oral hygiene; and

(III) restoration or improved ability to chew;

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

(vii) preventive restorative, replacement and repair services to achieve or restore functionality are provided after appropriate review if applicable per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP), in accordance with applicable Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services.** Nutrition Services are provided per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by the occupational therapist.

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of their practice.

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as all medical and osteopathic physicians, physician assistants and other licensed professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant within their employment. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have a current non-restrictive licensure with the Oklahoma State Board of Medical Licensure and Supervision. The physical therapist assistant must be employed by the physical therapist.

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include the use of physical therapist assistants, within the limits of their practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA's SoonerCare program.

(iii) The provision of services includes written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within their employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires non-restrictive licensure as a psychologist by the Oklahoma Psychologist Board of Examiners, or licensing board in the state in which service is provided.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP.

(i) Services are:

(I) intended to maximize a member's psychological and behavioral well-being; and

(II) provided in individual and group, six person maximum, formats.

(ii) A minimum of 15 minutes for each individual encounter and 15 minutes for each group encounter and record documentation of each treatment session is included and required.

(C) **Coverage limitations.**

(i) Limitations for psychological services are:

(I) Description: Psychotherapy services and behavior treatment services (individual): Unit: 15 minutes; and

(II) Description: Cognitive/behavioral treatment (group): Unit: 15 minutes.

(ii) Psychological services are authorized for a period not to exceed six months.

(I) Initial authorization is through the Developmental Disabilities Services Division (DDSD) case manager, with review and approval by the DDSD case management supervisor.

(II) Initial authorization must not exceed 192 units (48 hours of service).

(III) Monthly progress notes must include a statement of hours and type of service provided, and an empirical measure of member status as it relates to each objective in the member's IP.

(IV) If progress notes are not submitted to the DDSD case manager for each month of service provision, authorization for payment must be withdrawn until such time as progress notes are completed.

(iii) Treatment extensions may be authorized by the DDSD area manager based upon evidence of continued need and effectiveness of treatment.

(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDSD case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.

(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human Services (OKDHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours (96 units) of service per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours (48 units) may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours (560 units) of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a provider of psychiatric services requires a non-restrictive license to practice medicine in Oklahoma. Certification by the Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry

is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, and medication and prescription management and consultation provided to members who are eligible. Services are provided in any community setting as specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of 30 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 30 minutes, with a limit of 200 units per Plan of Care year.

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a provider of speech/language services requires non-restrictive licensure as a speech/language pathologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor/feeding activities provided to members who are eligible. Services are intended to maximize the member's community living skills and may be provided in any community setting as specified in the member's IP. The IP must include a practitioner’s prescription.

(i) For purposes of this Section, a practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants and other licensed professionals with prescriptive authority to order speech/language services in accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the OKDHS DDSD sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet the unique needs of members;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. ' 1025.2), unless a waiver is granted per 56 O.S. ' 1025.2; and

(iv) receive supervision and oversight from a

contracted agency staff with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment will not be made for:

(I) routine care and supervision that is normally provided by family; or

(II) services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members who require more than 40 hours per week of HTS must use staff members who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of any necessary support staff hours. Exceptions may be authorized when needed for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, and improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) DDSD case management supervisor review and approval is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an oversight agency approved by the OHCA. For pre-authorized HTS services, the service:

(I) provider will receive oversight from DDSD area staff; and

(II) must be pre-approved by the DDSD director or designee.

(C) **Coverage limitations.** HTS services are authorized as specified in OAC 317:40-5-110, 317:40-5-111, and 317:40-7-13, and OAC 340:100-3-33.1.

(i) A unit is 15 minutes.

(ii) Individual HTS services providers will be limited to a maximum of 40 hours per week regardless of the number of members served.

(iii) More than one HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.

(vi) HTS providers may not perform any job duties associated with other employment including on call duties, at the same time they are providing HTS services.

(9) **Self Directed HTS (SD HTS).**

SD HTS are provided per 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).**

SD GS are provided per 317:40-9-1.

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the State Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to members who are eligible. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a practitioner's prescription.

(i) For purposes of this Section, a practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA's SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) are at least 18 years of age;
(ii) complete the OKDHS DDSD sanctioned training curriculum;
(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. ' 1025.2, unless a waiver is granted per 56 O.S. ' 1025.2; and
(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.

(i) Prevocational services are provided to members who are not expected to:
(I) join the general work force; or
(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.
(ii) When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills.
(iii) All prevocational services will be reflected in the member's IP as habilitative, rather than explicit employment objectives.
(iv) Documentation must be maintained in the record of each member receiving this service noting that the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.
(v) Services include:
(I) center-based prevocational services as specified in OAC 317:40-7-6;
(II) community-based prevocational services as specified in OAC 317:40-7-5;
(III) enhanced community-based prevocational services as specified in OAC 317:40-7-12; and
(IV) supplemental supports as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based upon the number of hours the member participates in the service. All prevocational services and supported employment services combined may not exceed $25,000 per Plan of Care year. The following services may not be provided to the same member at the same time as prevocational services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training and as allowed per 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. ' 1025.2, unless a waiver is granted per 56 O.S. ' 1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waiver, including supervision and training.

(i) When supported employment services are provided at a work site in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) does not include payment for the supervisory activities rendered as a normal part of the business

setting.
(ii) Services include:
(I) job coaching as specified in OAC 317:40-7-7;
(II) enhanced job coaching as specified in OAC 317:40-7-12;
(III) employment training specialist services as specified in OAC 317:40-7-8; and
(IV) stabilization as specified in OAC 317:40-7-11.
(iii) Supported employment services furnished under HCBS Waiver are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.
(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA must be maintained in the record of each member receiving this service.
(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:
(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
(II) payments that are passed through to users of supported employment programs; or
(III) payments for vocational training that are not directly related to a member's supported employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made in accordance with OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported employment services combined cannot exceed $25,000 per Plan of Care year. The DDSD case manager assists the member to identify other alternatives to meet identified needs above the limit. The following services may not be provided to the same member at the same time as supported employment services:
(i) HTS;
(ii) Intensive Personal Supports;
(iii) Adult Day Services;
(iv) Daily Living Supports;
(v) Homemaker; or
(vi) Therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(14) **Intensive personal supports (IPS).**
(A) **Minimum qualifications.** IPS provider agencies must

have a current provider agreement with OHCA and OKDHS DDSD. Providers:
(i) are at least 18 years of age;
(ii) complete the OKDHS DDSD sanctioned training curriculum;
(iii) have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. ' 1025.2, unless a waiver is granted per 56 O.S. ' 1025.2;
(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities; and
(v) receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**
(i) IPS:
(I) are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and
(II) build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, recreational, and habilitation activities.
(ii) The member's IP must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.
(iii) DDSD case management supervisor review and approval is required.

(C) **Coverage limitations.** IPS are limited to 24 hours per day and must be included in the member's IP per OAC 317:40-5-151 and 317:40-5-153.

(15) **Adult day services.**
(A) **Minimum qualifications.** Adult day services provider agencies must:
(i) meet the licensing requirements set forth in 63 O.S. ' 1-873 *et seq*. and comply with OAC 310:605; and
(ii) be approved by the OKDHS DDSD and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive, and socialization skills, including the opportunity to interact with peers in order to promote maximum level of independence and function. Services are

provided in a non-residential setting separate from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are typically furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for up to a maximum of six hours daily, at which point a unit is one day. All services must be authorized in the member's IP.

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
PART 9. SERVICE PROVISIONS

317:40-5-110. Authorization for Habilitation Training Specialist Services

(a) Habilitation Training Specialist (HTS) Services are:

(1) authorized as a result of needs identified by the team and informed selection by the SoonerCare member;

(2) shared among SoonerCare members who are members of the same household or being served in the same community location;

(3) authorized only during periods when staff are engaged in purposeful activity which directly or indirectly benefits the service recipient. Staff must be physically able and mentally alert to carry out the duties of the job. At no time are HTS services authorized for periods during which the staff are allowed to sleep;

(4) not authorized to be provided in the home of the HTS unless the SoonerCare member and HTS reside in the same home; and

(5) directed toward the development or maintenance of a skill in order to achieve a specifically stated outcome. The service provided is not a function which the parent would provide for the individual without charge as a matter of course in the relationship among members of the nuclear family when the member resides in a family home.

(b) HTS Services may be provided in a group home as defined in 317:40-5-152 or community residential service settings defined in OAC 340:100-5-22.1 including:

(1) agency companion services as described in OAC 317:40-5-1 through 40-5-39;

(2) as provided in accordance with Daily Living Supports policy at OAC 317:40-5-150; and,

(3) as provided in accordance with Specialized Foster Care Policy at OAC 317:40-5-50 through 40-5-76; or

(4) services for people with Prader Willi syndrome.

(c) HTS Services are based on need and limited to no more than 12 hours per day per household in any setting other than

settings described in OAC 340:100-5-22.1, Community Residential Supports, except with approval in accordance with OAC 340:100-3-33, Service authorization, that the increased services are necessary to avoid institutional placement due to:

(1) the complexity of the family or caregiver support needs. Consideration must be given to:

(A) the age and health of the caregiver;

(B) the number of household members requiring the caregiver's time; and

(C) the accessibility of needed resources; and

(2) the resources of the family, caregiver, or household members that are available to the service recipient. Consideration must be given to the number of family members able to assist the caregiver and available community supports; and

(3) the resources of other agencies or programs available to the SoonerCare member or family. Consideration must be given to services available from:

(A) the public schools;

(B) the Oklahoma Health Care Authority;

(C) the Oklahoma Department of Rehabilitative Services;

(D) other OKDHS programs; and

(E) services provided by other local, state, or federal resources.

(d) When it appears that approval of an exception is needed to prevent institutional placement, the case manager submits the request which identifies the circumstances supporting the need for an exception to the area manager.

(e) The DDSD area manager or designee must approve, deny, or notify the case manager of issues preventing approval within 10 working days.

(f) HTS providers may not perform any job duties associated with other employment, including on call duties, at the same time they are providing HTS services.

(g) HTS services are limited to no more than 40 hours per week when the HTS resides in the same home as the service recipient. If additional hours of service are needed, they must be provided by someone living outside the home. Exceptions may be authorized when needed for members who receive services through the Homeward Bound Waiver.

(h) When the member is out of the home for school, work, adult day services or other non-HTS supported activities, the total number of hours of HTS and hours away from the home cannot exceed 12 hours per day unless an exception is granted in accordance with subsection c of this policy.

(i) In accordance with OAC 340:100-3-33.1, services must be provided in the most cost effective manner. When the need for

HTS services is expected to continue to exceed 9 hours daily, cost effective community residential services must be considered and requested in accordance with OAC 317:40-1-2. For adults, continuation of non-residential services in excess of 9 hours per day for more than one plan of care year will not be authorized except:

(1) when needed for members who receive services through the Homeward Bound Waiver;

(2) when determined by the division administrator or designee to be the most cost effective option; or

(3) as a transition period of 120 days or less to allow for identification of and transition to a cost effective residential option. Members who do not wish to receive residential services will be assisted to identify options that meet their needs within an average of 9 hours daily.