OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
November 20, 2014
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions: Chairman, Steven Crawford, M.D.

II. Public Comments (2 minute limit)

III. MAC Member Comments/Discussion

IV. **Action Item**: Approval of Minutes of the September 3, 2014 Medical Advisory Committee Meeting

V. Financial Report SFY 15 Q1: Gloria Hudson, Director of General Accounting

VI. SoonerCare Operations Update: Becky Pasternik-Ikard, Deputy State Medicaid Director

VII. Pharmacy Update: Quantity Limit Edit - Short-Acting Painkillers: Burl Beasley, Clinical Pharmacist

VIII. Stakeholder Survey: Sarah Coleman, University of Oklahoma Health Sciences Center

IX. SoonerCare and Insure Oklahoma Waiver Extension 2016-2018: Sharris Harris-Ososanya, Waiver Development Coordinator

X. Patient-Centered Medical Homes Audit Review: Beverly Rupert, QA/QI SC Compliance Manager

XI. Summary of Proposed Rule Amendments: Melinda Thomason, Health Policy Assistant Director

A. 14-34: DDS Psychological Evaluations/Waiver Services List

B. 14-23: DDS Third Party Employment

XII. **Action Item**: Vote on Proposed Rule Changes: Chairman, Steven Crawford, M.D.

XIII. Informational Items (No Discussion): Melinda Thomason, Health Policy Assistant Director

XIV. **Action Item**: Set meeting schedule for 2015 (3rd Thursday of odd-numbered months in 2015 are 1/15, 3/19, 5/21, 7/16, 9/17, 11/19): Chairman, Steven Crawford, M.D.

XV. **Action Item:** Election of Chairperson and Vice-Chairperson: Chairman, Steven Crawford, M.D.

XVI. New Business: Chairman, Steven Crawford, M.D.

XVII. Adjourn

Welcome

Dr. Crawford opened the meeting at 1:30 with introductions of a new delegate for the Oklahoma Psychological Association, Richard Walton, and a new alternate for the Association of Oklahoma Nurse Practitioners, Benny Venatta. He also announced the resignation of Bonnie Bellah who had been representing economically disadvantaged children and families who are Medicaid recipients.

Roll Call

Delegates present: Debbie Booten-Hiser, Mary Brinkley, Steven Crawford, Wanda Felty, Melissa Gastorf, Stanley Grogg (by phone), Tandie Hastings, Annette Mays, Dan McNeill, Daniel Post, Jason Rhynes, Carrie Slatton-Hodges, Rick Snyder, Jeff Tallent, Richard Walton, Phil Woodward, and Paul Wright (by phone).

Alternates present: Sarah Baker, Edd Rhoades, Joni Bruce, Frannie Pryor, Scott Raybern, and Victor Clay

Delegates absent: Tanya Case, David Cavallaro, Steve Goforth, Mark Jones, Denae Kirkpatrick, James Patterson, Anttonia Pratt-Reid, and William Simon

Approval of Minutes

The minutes of the June 11, 2014 meeting were noted to have a typo on page 4. With the correction of Dr. Hamil's title, Mr. Tallent moved to accept the minutes, Mr. Raybern seconded the motion and they were accepted unanimously.

Public Comments

Rick Salm of NuMotion, a complex rehab technology (CRT) provider spoke during public comments to report that his company had recently stopped providing some services to SoonerCare members because of the change in policy July 1, 2014. He spoke of his concern for the quality of complex rehab technology equipment and the wait time members will now have to endure. He expressed his support for a policy change still in development that would address pricing issues with (CRT) equipment.

Financial Report

Gloria Hudson, OHCA Director of General Accounting presented the summary of the year-end financial statements included in the MAC members' online packet. She noted the percentages of variances between actual figures and the budgets figures for State Fiscal Year (SFY) 2014. She also identified the Tax and Fee revenue coming from tobacco taxes. Projections through August 2014 indicated a continuation of expenditures being under budget.

Budget Review

Vickie Kersey, OHCA Purchasing Manager reported on the SFY 2015 budget. She said that it was balanced as required by statue. She also expressed gratitude to the state legislature and governor for not requiring a 5% reduction to OHCA's budget like most other state agencies that had reduced budgets. She identified many of the programs that had targeted budget reductions and explained the few that had budget increases. Insure Oklahoma was a program impacted by the federal reduction of income guidelines for participants from 200% to 100% of the federal poverty level.

SoonerCare Operations Update

Becky Pasternik-Ikard, OHCA Deputy State Medicaid Director, reported on stable SoonerCare enrollment figures for various eligibility groups the reduction of Insure Oklahoma members and Patient Centered Medical Homes. She also compared and contrasted SFY13 statistics for four units she supervises with SFY14 figures. The Behavioral Health Unit saw a slight increase in the number of prior authorizations issued and the reviewers' caseload. Referrals, however, had a significant rise when care coordination was transferred from the Health Management Program. She highlighted the number of new cases handled by the Population Care Management unit in the areas spanning the time when members are pregnant. Case Manager Nurses currently carry a case load of about 150. The efforts of the Member Services Unit for these members were documented as steady and the chart showing call volume showed a spike in the last quarter of 2013 when SoonerCare Eligibility merged with Member Services. Provider Services' charts showed the time a provider services representative had spent on the phone addressing high emergency room utilization, the call volume and the number of on-site provider visits made to improve provider knowledge. Dr. McNeil pointed out that the Insure Oklahoma beneficiaries had dropped from around 30,000 members to 17,000 and asked if there was money available to expand the program. Ms. Pasternik-Ikard reported that there were funds to expand and the Insure Oklahoma staff had been targeting potential members. She also pointed out that some of the former members who had lost eligibility had found insurance coverage through the exchange, healthcare.gov. Dr. Crawford vetted a rumor that there had been some difficulty enrolling in Medicaid and it was determined that the issue of insurance seekers getting denials before they could enroll had been resolved by OHCA and the Centers for Medicare and Medicaid Services (CMS).

Strategic Planning Conference Report

Buffy Heater, OHCA Planning & Performance Director, reported on the Strategic Planning Conference, formerly called the Board Retreat, held at the Samis Education Center of Oklahoma University's Health and Science Center on August 14 and 15. 184 attended in person and it was streamed live to Durant, Enid, and the agency. The conference, held in conjunction with the

Board Meeting, focused on the seven agency goals one to five years out. Ms. Heater reported that there were several common themes:

- Data usage and technological tools: improvement through Health Information Exchanges both public and private.
- Telemedicine: excitement mixed with caution to have a high integrity system.
- Mobile Technology: expanding the use of online and text communications.
- Collaboration: build and expand efforts across the Healthcare Cabinet, private industry and other non-health related state agencies
- Insure Oklahoma: seek permanency.
- Education: improve health literacy at the point of service using varied delivery venues.

Ms. Heater concluded her presentation with a hopeful note. The portfolio of the conference is posted across the agency and the process of prioritizing the ideas will develop a new synergy.

Action Items / Proposed Rule Changes

Isaac Lutz, Senior Policy Specialist, presented two Proposed Rule Changes (PRC).

- 14-17: changing the financial eligibility criteria for categorically eligible members, aged, blind, and disabled, to the test that Supplemental Security Insurance (SSI) uses. There was no additional discussion. Mr. Tallent moved the approval of the change, Ms. Pryor seconded, and the motion.
- 14-14: adding language that prohibits Home and Community Based Services (HCBS) case managers from providing direct services while making referrals for the same services (conflict of interest). There was no additional discussion. Mr. Tallent moved the approval of the change, Ms. Pryor seconded, and the motion passed with one nay vote.

Traylor Rains, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Policy Director, presented two PRCs with behavioral health implications.

- 14-15: limiting the number of hours behavioral health providers can bill per week to 35. A last minute change basing the calculation on a rolling four-week average was given to the members. Mr. Tallent moved to accept the change and Dr. McNeill seconded. Dr. Walton asked how the change would affect the $14.3M cost savings and Mr. Rains explained that a survey of claims showed that 4%, 218 providers, would be impacted by the change and shared a couple examples of over-billing. He went on to note that the change would not include psychological testing and would only apply to billing for Medicaid members. Dr. Walton commented that he thought that the approach was a backward way to prevent overbilling. When the vote was called, the move to accept the PRC was approved unanimously.

- 14-16: a new rule creating a "Health Home" that will create a provider type to integrate care management across the spectrum of health care allowing for new management codes and eliminating the duplication of other billing codes. Mr. Tallent moved for the acceptance of the PRC and Ms. Pryor seconded the motion. Dr. Crawford asked how the change would save money and Mr. Rains explained that some of the fee-for-service billing codes would be converted to a composite code. He also noted that the first two years of implementing the change would be financed by the federal government at a 90% rate. The motion to accept was passed without objection.

Informational Items

Mr. Lutz returned to inform the committee of four PRCs under research for possible future approval. They included the authorization process for private duty nursing (PDN), the method of paying for certified nurse's aide (CNA) training, restrictions on allergy services and immunotherapy, and the use of electronic referrals for specialty services. He also reported on two proposed amendments to the waivers to the State Plan granted by CMS; requiring a small copay for HCBS members getting preferred generic drugs and transitioning approximately 160 members from My Life My Choice, Sooner Seniors, and Medically Fragile to other operational units. Sylvia Lopez, OHCA Chief Medical Officer clarified that the proposed prior authorization process for PDN involved children with very complicated medical needs. Mr. Raybern asked if the removal of the zero copay was a federal mandate.

New Business

Dr. Crawford asked the members to be ready to discuss dates for 2015 MAC meetings at the November 20th MAC meeting.

Adjournment

Mr. Raybern made a motion to adjourn the meeting, Dr. Walton seconded, and the vote to adjourn was unanimous.

FINANCIAL REPORT

For the Three Months Ended September 30, 2014
Submitted to the CEO & Board

- Revenues for OHCA through September, accounting for receivables, were **$1,098,495,300** or **.5% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$963,033,542 or 1.3% under** budget.
- The state dollar budget variance through September is a **positive $7,095,343.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		3.5
Administration		.8
Revenues:		
Drug Rebate		.9
Taxes and Fees		.7
Overpayments/Settlements		1.2
Total FY 15 Variance	**$**	**7.1**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2015, For the Three Months Ended September 30, 2014

REVENUES	FY15 Budget YTD	FY15 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 310,130,349	$ 310,130,349	$ -	0.0%
Federal Funds	577,722,420	567,139,704	(10,582,715)	(1.8)%
Tobacco Tax Collections	11,222,905	12,623,825	1,400,920	12.5%
Quality of Care Collections	19,441,211	19,251,599	(189,612)	(1.0)%
Prior Year Carryover	61,029,661	61,029,661	-	0.0%
Federal Deferral - Interest	56,791	56,791	-	0.0%
Drug Rebates	58,788,252	61,159,854	2,371,602	4.0%
Medical Refunds	11,306,524	13,137,194	1,830,670	16.2%
Supplemental Hospital Offset Payment Program	49,905,864	49,905,864	-	0.0%
Other Revenues	4,043,555	4,060,460	16,906	0.4%
TOTAL REVENUES	**$ 1,103,647,531**	**$ 1,098,495,300**	**$ (5,152,230)**	**(0.5)%**

EXPENDITURES	FY15 Budget YTD	FY15 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 14,046,155**	**$ 12,603,014**	**$ 1,443,141**	**10.3%**
ADMINISTRATION - CONTRACTS	**$ 29,731,485**	**$ 28,556,824**	**$ 1,174,661**	**4.0%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	9,500,789	9,325,095	175,694	1.8%
Acute Fee for Service Payments:				
Hospital Services	222,960,358	221,057,012	1,903,346	0.9%
Behavioral Health	5,137,828	4,878,253	259,575	5.1%
Physicians	120,534,481	118,619,068	1,915,413	1.6%
Dentists	34,172,405	33,792,469	379,936	1.1%
Other Practitioners	10,570,983	10,370,511	200,472	1.9%
Home Health Care	5,099,183	5,107,803	(8,620)	(0.2)%
Lab & Radiology	19,757,220	19,611,141	146,079	0.7%
Medical Supplies	9,629,308	9,546,412	82,896	0.9%
Ambulatory/Clinics	30,516,508	30,510,461	6,047	0.0%
Prescription Drugs	112,471,556	109,930,483	2,541,073	2.3%
OHCA Therapeutic Foster Care	504,848	499,992	4,855	0.0%
Other Payments:				
Nursing Facilities	142,991,231	142,798,999	192,232	0.1%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	15,094,386	14,902,504	191,882	1.3%
Medicare Buy-In	33,801,880	32,357,616	1,444,264	4.3%
Transportation	18,123,691	18,106,881	16,810	0.1%
Money Follows the Person-OHCA	255,674	176,675	78,998	0.0%
Electonic Health Records-Incentive Payments	6,606,208	6,606,208	-	0.0%
Part D Phase-In Contribution	18,567,667	18,558,230	9,437	0.1%
Supplemental Hospital Offset Payment Program	115,117,891	115,117,891	-	0.0%
Total OHCA Medical Programs	**931,414,093**	**921,873,704**	**9,540,389**	**1.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 975,281,115**	**$ 963,033,542**	**$ 12,247,573**	**1.3%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 128,366,415**	**$ 135,461,758**	**$ 7,095,343**	

Oklahoma Health Care Authority

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2015, For the Three Months Ended September 30, 2014

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 9,363,075	$ 9,321,259	$ -	$ 37,980	$ -	$ 3,836	$ -
Inpatient Acute Care	252,707,519	154,498,232	121,672	1,024,929	92,872,986	297,219	3,892,482
Outpatient Acute Care	82,234,505	65,095,557	10,401	1,041,798	15,052,817	1,033,932	-
Behavioral Health - Inpatient	12,921,690	2,990,843	-	69,384	6,919,304		2,942,159
Behavioral Health - Psychiatrist	2,160,194	1,887,410	-	-	272,784	-	-
Behavioral Health - Outpatient	7,306,578	-	-	-	-	-	7,306,578
Behavioral Health Facility- Rehab	57,739,270	-	-	-	-	26,145	57,713,125
Behavioral Health - Case Management	4,323,631	-	-	-	-	-	4,323,631
Behavioral Health - PRTF	21,577,854	-	-	-	-	-	21,577,854
Residential Behavioral Management	5,518,094	-	-	-	-	-	5,518,094
Targeted Case Management	15,306,739	-	-	-	-	-	15,306,739
Therapeutic Foster Care	499,992	499,992	-	-	-	-	-
Physicians	132,973,884	117,098,115	14,525	1,502,299	-	1,506,428	12,852,517
Dentists	33,797,299	33,788,371	-	4,830	-	4,097	-
Mid Level Practitioners	714,568	708,249	-	5,948	-	372	-
Other Practitioners	9,687,199	9,549,194	111,591	25,309	-	1,105	-
Home Health Care	5,111,771	5,101,363	-	3,969	-	6,440	-
Lab & Radiology	20,065,480	19,466,393	-	454,339	-	144,748	-
Medical Supplies	9,611,669	8,842,991	677,884	65,257	-	25,537	-
Clinic Services	30,163,676	28,096,476	-	167,900	-	53,807	1,845,493
Ambulatory Surgery Centers	2,404,809	2,353,850	-	44,631	-	6,328	-
Personal Care Services	3,249,133	-	-	-	-	-	3,249,133
Nursing Facilities	142,798,999	89,514,268	53,282,749	-	-	1,982	-
Transportation	18,024,359	17,345,190	659,387	-	-	19,782	-
GME/IME/DME	36,514,483	-	-	-	-	-	36,514,483
ICF/IID Private	14,902,504	12,200,380	2,702,124	-	-	-	-
ICF/IID Public	7,634,906	-	-	-	-	-	7,634,906
CMS Payments	50,915,846	50,757,505	158,342	-	-	-	
Prescription Drugs	112,165,035	109,421,152	-	2,234,552	-	509,331	-
Miscellaneous Medical Payments	82,521	80,758	-	-	-	1,764	-
Home and Community Based Waiver	44,852,877	-	-	-	-	-	44,852,877
Homeward Bound Waiver	21,739,067	-	-	-	-	-	21,739,067
Money Follows the Person	3,945,467	176,675	-	-	-	-	3,768,792
In-Home Support Waiver	6,225,950	-	-	-	-	-	6,225,950
ADvantage Waiver	42,928,968	-	-	-	-	-	42,928,968
Family Planning/Family Planning Waiver	1,977,046	-	-	-	-	-	1,977,046
Premium Assistance*	10,479,709	-	-	10,479,709	-	-	-
Electronic Health Records Incentive Payments	6,606,208	6,606,208	-	-	-	-	-
Total Medicaid Expenditures	**$ 1,241,232,575**	**$ 745,400,431**	**$ 57,738,674**	**$ 17,162,833**	**$ 115,117,891**	**$ 3,642,853**	**$ 302,169,892**

* Includes $10,392,797.34 paid out of Fund 245

Oklahoma Health Care Authority

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2015, For the Three Months Ended September 30, 2014

		FY15 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	126,392,578
Federal Funds		191,682,922
TOTAL REVENUES	**$**	**318,075,500**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	44,852,877
Money Follows the Person		3,768,792
Homeward Bound Waiver		21,739,067
In-Home Support Waivers		6,225,950
ADvantage Waiver		42,928,968
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		7,634,906
Personal Care		3,249,133
Residential Behavioral Management		4,190,158
Targeted Case Management		12,549,807
Total Department of Human Services		**147,139,657**
State Employees Physician Payment		
Physician Payments		12,852,517
Total State Employees Physician Payment		**12,852,517**
Education Payments		
Graduate Medical Education		-
Graduate Medical Education - Physicians Manpower Training Commission		1,294,874
Indirect Medical Education		31,865,924
Direct Medical Education		3,353,685
Total Education Payments		**36,514,483**
Office of Juvenile Affairs		
Targeted Case Management		653,079
Residential Behavioral Management		1,327,936
Total Office of Juvenile Affairs		**1,981,014**
Department of Mental Health		
Case Management		4,323,631
Inpatient Psychiatric Free-standing		2,942,159
Outpatient		7,306,578
Psychiatric Residential Treatment Facility		21,577,854
Rehabilitation Centers		57,713,125
Total Department of Mental Health		**93,863,346**
State Department of Health		
Children's First		522,614
Sooner Start		640,375
Early Intervention		1,032,998
Early and Periodic Screening, Diagnosis, and Treatment Clinic		444,893
Family Planning		(26,349)
Family Planning Waiver		1,991,241
Maternity Clinic		7,727
Total Department of Health		**4,613,499**
County Health Departments		
EPSDT Clinic		232,774
Family Planning Waiver		12,154
Total County Health Departments		**244,929**
State Department of Education		**49,511**
Public Schools		**498,729**
Medicare DRG Limit		**2,250,000**
Native American Tribal Agreements		**519,724**
Department of Corrections		**613,325**
JD McCarty		**1,029,157**
Total OSA Medicaid Programs	**$**	**302,169,892**
OSA Non-Medicaid Programs	**$**	**20,160,645**
Accounts Receivable from OSA	**$**	**4,255,037**

SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
Fiscal Year 2015, For the Three Months Ended September 30, 2014

REVENUES		FY 15 Revenue
SHOPP Assessment Fee		$ 49,854,993
Federal Draws		73,698,590
Interest		26,533
Penalties		24,337
State Appropriations		(7,700,000)
TOTAL REVENUES		$ 115,904,454

EXPENDITURES	Quarter	FY 15 Expenditures
Program Costs:	7/1/14 - 9/30/14	
Hospital - Inpatient Care	92,872,986	$ 92,872,986
Hospital -Outpatient Care	15,052,817	$ 15,052,817
Psychiatric Facilities-Inpatient	6,919,304	$ 6,919,304
Rehabilitation Facilities-Inpatient	272,784	$ 272,784
Total OHCA Program Costs	115,117,891	$ 115,117,891
Total Expenditures		$ 115,117,891

CASH BALANCE	$ 786,563

*** Expenditures and Federal Revenue processed through Fund 340

SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2015, For the Three Months Ended September 30, 2014

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 19,241,884**	**$ 19,241,884**
Interest Earned	**9,714**	**9,714**
TOTAL REVENUES	**$ 19,251,599**	**$ 19,251,599**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 52,375,095	$ 18,844,559	
Eyeglasses and Dentures	68,614	24,691	
Personal Allowance Increase	839,040	301,887	
Coverage for Durable Medical Equipment and Supplies	677,884	243,903	
Coverage of Qualified Medicare Beneficiary	258,189	92,896	
Part D Phase-In	158,342	158,342	
ICF/IID Rate Adjustment	1,343,204	483,285	
Acute Services ICF/IID	1,358,919	488,939	
Non-emergency Transportation - Soonerride	659,387	237,248	
Total Program Costs	**$ 57,738,674**	**$ 20,875,749**	**$ 20,875,749**
Administration			
OHCA Administration Costs	$ 123,126	$ 61,563	
PHBV - Quality of Care Expense	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 123,126**	**$ 61,563**	**$ 61,563**
Total Quality of Care Fee Costs	**$ 57,861,800**	**$ 20,937,312**	
TOTAL STATE SHARE OF COSTS			**$ 20,937,312**

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

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2015, For the Three Months Ended September 30, 2014

REVENUES	FY 14 Carryover	FY 15 Revenue	Total Revenue
Prior Year Balance	$ 13,950,701	$ -	$ 7,154,427
State Appropriations	-	-	-
Tobacco Tax Collections	-	10,382,971	10,382,971
Interest Income	-	74,031	74,031
Federal Draws	160,262	6,853,759	6,853,759
All Kids Act	(6,720,041)	25,086	25,086
TOTAL REVENUES	**$ 7,390,922**	**$ 17,335,847**	**$ 24,465,188**

EXPENDITURES		FY 14 Expenditures	FY 15 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 10,323,169	$ 10,323,169
	College Students		86,911	31,271
	All Kids Act		69,628	69,628
Individual Plan				
	SoonerCare Choice		$ 36,636	$ 13,182
	Inpatient Hospital		1,006,924	362,291
	Outpatient Hospital		1,033,314	371,786
	BH - Inpatient Services-DRG		67,079	24,135
	BH -Psychiatrist		-	-
	Physicians		1,503,875	541,094
	Dentists		4,454	1,603
	Mid Level Practitioner		5,498	1,978
	Other Practitioners		25,091	9,028
	Home Health		3,969	1,428
	Lab and Radiology		450,609	162,129
	Medical Supplies		59,933	21,564
	Clinic Services		166,887	60,046
	Ambulatory Surgery Center		38,900	13,996
	Prescription Drugs		2,204,091	793,032
	Miscellaneous Medical		-	-
	Premiums Collected		-	(131,669)
Total Individual Plan			**$ 6,607,259**	**$ 2,245,623**
	College Students-Service Costs		**$ 75,773**	**$ 27,263**
	All Kids Act- Service Costs		**$ 93**	**$ 34**
Total OHCA Program Costs			**$ 17,162,833**	**$ 12,696,987**
Administrative Costs				
	Salaries	$ 30,565	$ 304,222	$ 334,786
	Operating Costs	109,709	138,037	247,745
	Health Dept-Postponing	-	-	-
	Contract - HP	96,221	170,138	266,359
Total Administrative Costs		**$ 236,495**	**$ 612,396**	**$ 848,891**
Total Expenditures				**$ 13,545,878**
NET CASH BALANCE		**$ 7,154,427**		**$ 10,919,310**

SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2015, For the Three Months Ended September 30, 2014

REVENUES	FY 15 Revenue	State Share
Tobacco Tax Collections	$ 207,164	$ 207,164
TOTAL REVENUES	**$ 207,164**	**$ 207,164**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 4,744	$ 1,195	
Inpatient Hospital	297,219	74,869	
Outpatient Hospital	1,033,932	260,447	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,982	499	
Physicians	1,506,428	379,469	
Dentists	4,097	1,032	
Mid-level Practitioner	372	94	
Other Practitioners	1,105	278	
Home Health	6,440	1,622	
Lab & Radiology	144,748	36,462	
Medical Supplies	25,537	6,433	
Clinic Services	53,807	13,554	
Ambulatory Surgery Center	6,328	1,594	
Prescription Drugs	509,331	128,300	
Transportation	19,782	4,983	
Miscellaneous Medical	856	216	
Total OHCA Program Costs	$ 3,616,708	$ 911,049	
OSA DMHSAS Rehab	$ 26,145	$ 6,586	
Total Medicaid Program Costs	$ 3,642,853	$ 917,635	
TOTAL STATE SHARE OF COSTS			**$ 917,635**

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.

September 2014 Data for November 2014 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2014	Enrollment September 2014	Total Expenditures September 2014	Average Dollars Per Member Per Month September 2014
SoonerCare Choice Patient-Centered Medical Home			559,363	**538,008**	**$117,764,029**	
	Lower Cost	*(Children/Parents; Other)*		490,867	$79,555,060	$162
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		47,141	$38,208,969	$811
SoonerCare Traditional			196,936	**238,004**	**$184,180,985**	
	Lower Cost	*(Children/Parents; Other)*		127,308	$59,213,249	$465
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		110,696	$124,967,736	$1,129
SoonerPlan*			48,266	**42,156**	**$432,976**	$10
Insure Oklahoma			23,567	**17,309**	**$5,135,133**	
	Employer-Sponsored Insurance		14,795	12,773	$3,313,883	$259
	*Individual Plan**		8,772	4,536	$1,821,251	$402
TOTAL			**828,131**	**835,477**	**$307,513,122**	

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 $40,034,237 are excluded.

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

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

Net Enrollee Count Change from Previous Month Total	(234)

New Enrollees	15,899

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

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

Medicare and SoonerCare		Monthly Average SFY2014	Enrolled September 2014
Dual Enrollees		**109,653**	**110,429**
	Child	*192*	190
	Adult	*109,461*	110,239

		Monthly Average SFY2014	Enrolled September 2014	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,358**	**15,219**	**$3,527**
	Child	63	58	
	Adult	15,295	15,161	

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

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2014	Enrolled September 2014
Total Providers		**38,330**	**40,161**
	In-State	29,277	30,023
	Out-of-State	9,053	10,138

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

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

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2014	*Enrolled September 2014**	Monthly Average SFY2014	Enrolled September 2014
Physician	*8,452*	*8,987*	*13,597*	14,982
Pharmacy	*936*	*887*	*1,266*	1,159
Mental Health Provider	*4,864*	*4,385*	*4,902*	4,432
Dentist	*1,069*	*1,084*	*1,206*	1,236
Hospital	*183*	*191*	*685*	881
Optometrist	*565*	*603*	*594*	637
Extended Care Facility	*356*	*349*	356	350

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

Total Primary Care Providers**	*5,410*	*5,808*	7,011	7,640
Patient-Centered Medical Home	*2,099*	*2,272*	2,188	2,376

**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.

SOONERCARE CHOICE/INSURE OKLAHOMA WAIVER RENEWAL SUMMARY

The Oklahoma Health Care Authority (OHCA) announces its intent to submit a request for renewal of the SoonerCare Choice/Insure Oklahoma Section 1115 Research and Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS). We request to continue the demonstration for another three years from January 1, 2016 through December 31, 2018.

The State currently has approval to operate the SoonerCare Waiver through December 31, 2015. The State will apply to renew the current waiver without any changes for the extension request.

The waiver allows the SoonerCare program to operate the Primary Care Case Management service delivery model whereby members are enrolled with a patient-centered medical home (PCMH) and establishes federal authorization for the Insure Oklahoma (IO) program. The Insure Oklahoma program offers both an Employer Sponsored Insurance (ESI) program and the Individual Plan (IP).

OHCA will continue to take into consideration comments/suggestion from the public received through November 30, 2014 in order to prepare to submit the application.

To obtain copies of the proposed renewal and/or leave public comment, interested parties may view or download the proposal from www.okhca.org.

OHCA welcomes your comments on these plans to request authorization to maintain the SoonerCare Choice and Insure Oklahoma programs. Comments and questions can be submitted online at http://www.okhca.org or you may contact Sherris Harris-Ososanya Coordinator of the OHCA Waiver Development & Reporting Unit by email at Sherris.Harris-Ososanya@okhca.org by phone at (405) 522-7507.

November MAC
Proposed Rule Amendment Summaries

A face to face tribal consultation regarding the following proposed changes was held Tuesday, November 4, 2014 in the Board Room of the OHCA.

The following rules were posted for comment on October 22, 2014 through November 20, 2014.

14-34 DDS Psychological Evaluations/Waiver Services List — The proposed revisions are to implement policy changes recommended during the Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) annual policy review process. Home and Community-Based Services (HCBS) Waiver's rules for persons with intellectual disabilities or certain persons with related conditions are amended to: (1) include timeframes for how long psychological evaluations are considered valid to determine eligibility for DDS HCBS Waiver services; (2) include timeframes for reporting any address changes or other contact information to DHS; and (3) provide timeframes when an individual is removed from the Request for Waiver Services List when the individual fails to respond or does not provide DHS requested information.
Budget Impact: Budget Neutral

14-23 DDS Third Party Employment — Developmental Disabilities Services (DDS) policy is revised to comply with 29 CFR 552.109 regarding domestic service employees employed by third-party employers, or employers other than the individual receiving services, or his or her family, or household. The regulation precludes third party employers from claiming the companion exemption.
Budget Impact: Budget Neutral

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

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

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

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

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

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

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

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

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

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

mental health facility, nursing facility, residential care facility ~~as described in~~ per Section 1-819 of Title 63 of Oklahoma Statutes, or Intermediate Care facility for ~~persons with mental retardation (ICF/MR)~~ individuals with intellectual disabilities (ICF/IID). The individual may not be receiving ~~DDSD~~ Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

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

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

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

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

(iv) be three years of age or older;

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

(vi) reside in:

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

(II) his or her own home;

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

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

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

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

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

this Section;
(ii) be determined to have a disability and a diagnosis of intellectual disability by the SSA; or
(iii) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by ~~the DDSD~~ DDS and ~~to~~ be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or
(iv) be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA/LOCEU; and
(v) be three years of age or older; and
(vi) be determined by the OHCA/LOCEU, to meet the ~~ICF/MR~~ ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122; and
(vii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the ~~DDSD Division Director~~ DDS director or designee.

(C) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the person must:
(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;
(ii) meet all criteria for HCBS Waiver services ~~given~~ listed in ~~subsection~~ (c) of this Section; and
(iii) be determined to have a disability and a diagnosis of intellectual disability by SSA; or
(iv) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition per OAC 317:35-9-45 by ~~DDSD~~ DDS and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or
(v) have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and
(vi) meet ~~the ICF/MR~~ ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122 by the OHCA/LOCEU.

(2) The person desiring services through any of the Waivers listed in ~~subsection~~ (a) of this Section participates in

diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, by a licensed ~~Psychologist or State staff supervised by a licensed Psychologist, current within 12 months of requested approval date,~~ psychologist that includes:

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

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

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

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

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

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

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

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

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

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

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

(5) A determination of need for ~~ICF/MR~~ ICF/IID Institutional

Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

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

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

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

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

(A) is found to be ineligible for services;

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

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

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

(E) declines an offer of Waiver services

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

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

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

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

(f) **Admission protocol.** Initiation of services funded through ~~a~~ an HCBS Waiver occurs in chronological order from the Request for Waiver Services List in accordance with ~~subsection~~ (d) of this Section based on the date of ~~DDSD~~ DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or ~~his or her legal guardian~~ the individual acting on the member's behalf, and upon determination of eligibility, in accordance with ~~subsection~~ (c) of this Section. Exceptions to the chronological requirement may be made when:

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

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

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

(I) is hospitalized;

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

(III) is permanently incapacitated; or

(IV) ~~has~~ died; and

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

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

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

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

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

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

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

(4) individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30 continuous months prior to January 1, 1989,and who are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted pursuant to the provisions of 42 CFR 483.100 et seq to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community or Homeward Bound Waiver.

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

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

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

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

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

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

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

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA/LOCEU when a determination of disability has not been made by the Social Security Administration. The OHCA/LOCEU determines categorical

relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders. ~~DDSD~~ DDS may require a new ~~diagnostic~~ psychological evaluation ~~in accordance with paragraph (c)(2) of this subsection~~ and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status ~~determined under paragraph (c)(2) of this Section~~ has been noted.

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

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

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

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

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

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

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

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

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

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

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

(11) ~~when~~ there is sufficient evidence ~~that~~ the member or ~~his/her legal representative~~ the individual acting on the member's behalf has engaged in fraud or misrepresentation,

failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

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

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

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

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

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

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

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

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

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

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

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

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

(4) a member's SoonerCare eligibility is re-established

within 90 calendar days of the date of SoonerCare ineligibility.

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

317:40-5-3. Agency companion services

(a) Agency companion services (ACS) are:

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

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

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

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

(b) An agency companion:

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

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

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

(4) may not provide companion services to more than two

members at any time;
(5) household may not serve more than three members through any combination of companion or respite services;
(6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5.

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

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

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

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

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

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

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

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

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

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

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

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

(1) Therapeutic leave:

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

(B) is claimed when the:

(i) ~~the~~ member does not receive ACS for 24 consecutive

hours due to:

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

(II) vacation without the companion; or

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

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

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

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

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

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

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

(e) Habilitation Training Specialist (HTS) services:

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

(A) sleeping at night; or

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

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

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

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

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

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

~~(2) contractor model does not include funding for the~~

~~provider agency for the provision of benefits to the companion.~~

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

(1) determined by authorized ~~DDSD~~ DDS staff ~~in accordance with~~ per levels described in (A) through(D); and

(2) re-evaluated when the member has a change in agency companion providers ~~which~~ that includes a change in agencies or individual companion providers.

(A) **Intermittent level of support.** Intermittent level of support is authorized when the member:

(i) requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) may be able to spend short periods of time unsupervised inside and outside the home; and

(iii) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(B) **Close level of support.** Close level of support is authorized when the member requires:

(i) ~~requires~~ regular, frequent and sometimes constant physical assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) ~~requires~~ extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and

(iii) ~~requires~~ assistance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support.** Enhanced level of support is authorized when the member:

(i) is totally dependent on others for:

(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;

(ii) demonstrates ongoing complex medical issues requiring specialized training courses per OAC 340:100-5-26; or

(iii) has behavioral issues that requires a protective intervention plan (PIP) with a restrictive or intrusive procedure ~~as defined in~~ per OAC 340:100-1-2. The PIP must:

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) the Plan;

(4) the POC; and

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

(h) The Plan reflects the amount of room and board the member pays to the companion. The provider must use the room and board reimbursement payment to meet the member's needs. Items purchased with the room and board reimbursement payment includes

housing and food. ~~If the amount exceeds $450, the additional amount must be:~~

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

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

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

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

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

(2) recommended by the Team; and

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

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

~~(a) The matching of the lifestyles and personalities of a companion and a service recipient and the overall compatibility of the companion with the service recipient are the most critical elements of the Agency Companion Services (ACS) program. The past and present relationship the service recipient has with the potential companion is the most important consideration in the companion selection process.~~

~~(b) In addition to considering the relationship between the service recipient and the companion, the case manager, the service recipient or legal guardian, and the service recipient's provider agency must reach consensus regarding the criteria listed in this Section before the approval process described in OAC 317:40-5-40 begins.~~

~~(1) The companion must have a relationship with the service recipient. Exceptions may be made by the service recipient's personal support team (Team) upon the recommendation of the Developmental Disabilities Services Division (DDSD) case manager, Division of Children and Family Services (DCFS) worker, or the Adult Protective Services (APS) worker, when appropriate.~~

~~(2) The companion must have the commitment and skills to meet the individual needs of the service recipient.~~

~~(3) The companion must understand the level of commitment required for the ACS program and how the commitment will affect the companion's personal life.~~

~~(4) The companion must understand how the commitment to the ACS program will impact the companion's family.~~

~~(5) The companion must demonstrate the ability to establish and maintain a positive relationship with the service recipient, particularly when stressful situations occur.~~

~~(6) The companion must demonstrate the ability to work collaboratively with others in the service process.~~
~~(7) Neither a service recipient's spouse nor the parent of a minor child may serve as that person's companion. A family member serving as companion must meet all requirements for the ACS program given in this Subchapter.~~
~~(8) The Chief Executive Officer (CEO) of a provider agency may not serve as a companion.~~

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

(a) ~~Providers of Agency Companion Services (ACS)~~ Companions are required to meet all applicable standards outlined in this subchapter and competency-based training ~~described in OAC~~ per Oklahoma Administrative Code(OAC) 340:100-3-38. The provider agency ensures ~~that~~ all companions meet the criteria in this Section.

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

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

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

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

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

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

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

(6) ~~with assistance from the DDSD case manager and the provider agency program coordination staff,~~ develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the

companion is responsible, as identified in the Plan~~;~~.

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

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

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

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

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

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

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

(A) traveling out of state;

(B) overnight visits; or

(C) involvement of the member in any publicity;

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

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

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

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

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

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

(18) ensures ~~that~~ the member's confidentiality is maintained per OAC 340:100-3-2;
(19) supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
(20) implements training and provides supports that enable the member to actively join in community life;
(21) does not serve as representative payee for the member without a written exception from the ~~DDSD~~ DDS area manager or designee~~;~~.
(A) The written exception is retained in the member's home record.
(B) When serving as payee, the companion complies ~~with the requirements~~ of OAC 340:100-3-4 requirements~~.~~;
(22) ensures the member's funds are properly safeguarded~~.~~;
(23) obtains prior approval from the member's representative payee when making a purchase of over $50~~.00~~ with the member's funds;
(24) allows ~~the~~ provider agency and DDS staff ~~and DDSD staff~~ to make announced and unannounced visits to the home;
(25) develops an Evacuation Plan, using ~~OKDHS~~ DHS Form 06AC020E, Evacuation/Escape Plan, for the home and conducts training with the member;
(26) conducts fire and weather drills at least quarterly and documents the fire and weather drills using Form 06AC021E, Fire and Weather Drill Record;
(27) develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using Form 06AC022E, Personal Possession Inventory;
(28) supports the member's employment program by:
(A) assisting the member to wear appropriate work attire; and
(B) contacting the member's employer as outlined by the Team and in the Plan; ~~and~~
(29) is responsible for the cost of ~~their~~ the member's meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution;
(30) for adults, reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, and/or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes to the DHS Office of Client Advocacy (OCA);
(31) for children, reports abuse, neglect, sexual abuse, or sexual exploitation per Section 1-2-101 of Title 10A of the

Oklahoma Statutes to the Child Abuse and Neglect Hotline at 1-800-522-3511; ~~and~~

(32) follows all applicable rules promulgated by the Oklahoma Health Care Authority and ~~DDSD~~ DDS, including:

(A) OAC 340:100-3-40;
(B) OAC 340:100-5-50 through 100-5-58;
(C) OAC 340:100-5-26;
(D) OAC 340:100-5-34;
(E) OAC 340:100-5-32;
(F) OAC 340:100-5-22.1;
(G) OAC 340:100-3-27;
(H) OAC 340:100-3-38 ; ~~and~~
(I) OAC 340:100-3-34;

(33) is neither the member's spouse, nor when the member is a minor child, the member's parent. A family member servicing as companion must meet all requirements listed in this Subchapter; and

(34) is not the Chief Executive Officer of a provider agency.

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

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

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

(1) is 21 years of age or older;

(2) has attended the ~~DDSD~~ DDS or provider agency ACS orientation;

(3) ~~is employed by, or~~ contracts with~~,~~ a provider agency having a current contract with the Oklahoma Health Care Authority to provide ACS;

(4) submits the completed ~~DDSD~~ DDS application packet ~~in accordance with OAC~~ per Oklahoma Administrative Code (OAC) 317:40-5-40 within the required time period to designated ~~DDSD~~ DDS staff or the provider agency staff;

(5) cooperates with ~~the~~ designated ~~DDSD staff~~ DDS or ~~the~~ provider agency staff in the development and completion of the home profile approval process ~~described in~~ per OAC 317:40-5-40; and

(6) has completed all training required by OAC 340:100-3-38, including medication administration training, and all provider

agency pre-employment training ~~as described in~~ per OAC 317:40-5-40.

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

[REVOKED]

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

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

~~(2) approved relief and emergency back-up plan;~~

~~(3) revised Individual Plan;~~

~~(4) revised Plan of Care; and~~

~~(5) placement of the member in the ACS home.~~

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

[REVOKED]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) ~~the~~ request of the companion;and

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

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

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

~~(6) breach of confidentiality;~~

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

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

~~(9) continued failure to implement the Individual Plan, per OAC 340:100-5-50 through 100-5-58;~~

~~(10) failure to complete and maintain training per OA~~C ~~340:10-3-38;~~

~~(11) failure to report changes in the household;~~

~~(12) failure or inability of the home to meet standards per OAC 317:40-5-40;~~

~~(13) continued failure to follow applicable Oklahoma Department of Human Services or Oklahoma Health Care Authority rules;~~

~~(14) decline of the companion's health to the point that he or she can no longer meet the needs of the member;~~

~~(15) employment by the companion without prior approval by the DDSD area programs manager for residential services; or~~

~~(16) domestic disputes which may result in emotional instability of the member.~~

(b) Upon termination of the placement~~:~~

~~(1) the property of the member or the state is removed immediately by the member or his or her designee; and~~

~~(2)~~ the Team meets to develop an orderly transition plan and arranges for the member's property to be moved as necessitated by the transition plan.

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

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

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

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

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

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

(e) ~~If~~ When the provider agency serves as the member's representative payee, the provider agency must adhere to ~~the requirements of~~ OAC 340:100-3-4.1 requirements.

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

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

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

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

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

(h) ~~When the provider agency has knowledge of problems occurring in the placement, the provider agency's program coordination staff immediately schedules a meeting with the companion, the member, the member's legal guardian or advocate, the DDSD case~~

~~manager and other appropriate DDSD staff to resolve the issues involved. If resolution of the issues does not occur at the meeting, any participant is to contact the DDSD area manager or designee and the provider agency for resolution.~~ Team members, including the provider agency program coordinator, companion, member, legal guardian, advocate, and DDS case manager work together to resolve issues to ensure the member's needs are met and the shared living arrangement is successful.

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

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

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

~~(l)~~(k) ~~The responsibilities of the provider~~ Provider agency's program coordination staff responsibilities are to:

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

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

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

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

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

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

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

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

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

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

(1) knowledgeable about the member;

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

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

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

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

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

317:40-5-40. Home profile process

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

(1) agency companion services (ACS);

(2) specialized foster care (SFC) services;

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

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

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

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

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

(2) an explanation of:

(A) the home profile process;

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

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

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

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

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

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

(i) an Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search, including the Oklahoma Department of Public Safety (DPS), Sex

Offender Registry and Mary Rippy Violent Offender Registries;

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

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

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

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

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

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

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

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

(II) child abuse or neglect;

(III) domestic abuse;

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

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

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

(5) ~~OKDHS~~ (DHS) Form 06AC015E, Agency Companion/Specialized Foster Care Employment Record;
(6) ~~OKDHS~~ (DHS) Form 06AC016E, ~~DDSD~~ (DDS)Reference Information Waiver;
(7) ~~OKDHS~~ (DHS) Form 06AC029E, Employer Reference Letter; and
(8) ~~OKDHS~~ (DHS) Form 06AC013E, Pre-Screening for Specialized Foster Care/Agency Companion Services.

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

(1) The applicant completes the required forms and returns the forms to the ~~DDSD~~ DDS address provided. Required forms include ~~OKDHS~~ DHS Forms:
(A) 06AC008E, Specialized Foster Care/Agency Companion Services Application;
(B) 06AC009E, Financial Assessment;
(C) 06AC011E, Family Health History;
(D) 06AC018E, Self Study Questionnaire;
(E) 06AC019E, Child's Questionnaire;
(F) 06AC010E, Medical Examination Report, ~~if~~ when Form 06AC011E indicates conditions that may interfere with the provision of services;
(G) 06AC017E, Insurance Information; and
(H) 06AC020E, Evacuation/Escape Plan.

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

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

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

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

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

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

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

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

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

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

(1) **General conditions.**

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

(B) The home must:

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

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

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

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

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

(i) guards and rails on stairways;

(ii) wheelchair ramps;

(iii) widened doorways;

(iv) grab bars;

(v) adequate lighting;

(vi) anti-scald devices; and

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

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

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

(2) **Sanitation.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) be provided for each member.

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

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

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

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

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

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

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

(i) Each bed must have clean bedding in good condition consisting of a mattress pad, bedspread, two sheets, pillow, pillowcase, and blankets adequate for the weather.

(ii) Sheets and pillowcases must be laundered at least weekly or more often if necessary.

(iii) Waterproof mattress covers must be used for members who are incontinent;

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

(i) Members must be allowed to keep and use reasonable amounts of personal belongings and have private, secure storage space.

(ii) The provider assists the member in furnishing and decorating the member's bedroom.

(iii) Window coverings must be in good condition and allow privacy for members;

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

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

(5) **Food.**

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

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

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

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

(6) **Phone.**

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

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

(7) **Safety.**

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

(B) Heating, in accordance with manufacturer's specifications, and electrical equipment, including wood stoves, must be installed in accordance with all applicable fire and life safety codes. Such equipment must be used and maintained properly and in good repair.

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

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

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

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

(8) **Emergencies.**

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

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

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

(D) The provider:

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

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

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

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

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

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

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

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

(9) **Special hazards.**

(A) Firearms and other dangerous weapons must be stored in a locked permanent enclosure. Ammunition must be stored in a separate locked location. Providers are prohibited from assisting members to obtain, possess, or use dangerous or deadly weapons per OAC 340:100-5-22.1.

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

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

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

(10) **Vehicles.**

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

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

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

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

(1) evaluating the applicant's:

(A) interest and motivation;

(B) life skills;

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

(D) methods of behavior support and discipline;

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

(F) income and money management; and

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

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

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

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

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

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

(iii) express an understanding of the commitment required as a provider of services;

(iv) express an understanding of the impact the arrangement will have on personal and family life;

(v) demonstrates the ability to establish and maintain positive relationships, especially during stressful situations; and

(C) ~~if the applicant does not meet standards per OAC 317:40-5-40, ensures the final recommendation includes:~~

~~(i) basis for the denial decision; and~~

~~(ii) effective date for determining the applicant as not meeting standards. Reasons for denying a profile may include, but are not limited to:~~

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

~~(II) a physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;~~
~~(III) the age, health, or any other condition of the applicant that impedes the applicant's ability to provide appropriate care for a member;~~
~~(IV) relationships in the applicant's household are unstable and unsatisfactory;~~
~~(V) the mental health of the applicant or other family or household member impedes the applicant's ability to provide appropriate care for a member;~~
~~(VI) references are guarded or have reservations in recommending the applicant;~~
~~(VII) the applicant fails to complete the application, required training, or verifications in a timely manner as requested or provides information that is incomplete, inconsistent, or untruthful; or~~
~~(VIII) the home is determined unsuitable for the member requiring placement;~~
approves only applicants who can fulfill the expectations of the role of service provider;

(D) ~~notifies the applicant in writing of the final recommendation; and~~ when the applicant does not meet standards per OAC 317:40-5-40, ensures the final recommendation includes:

(i) a basis for the denial decision; and

(ii) an effective date for determining the applicant does not meet standards. Reasons for denying a request to be a provider may include, but are not limited to:

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

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

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

(IV) relationships in the applicant's household that are unstable and unsatisfactory;

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

(VI) references who are guarded or have reservations in recommending the applicant;
(VII) the reason the applicant failed to complete the application, required training, or verifications in a timely manner as requested or provided incomplete, inconsistent, or untruthful information;
(VIII) the home is determined unsuitable for the member requiring placement;
(IX) confirmed abuse, neglect, or exploitation of any person;
(X) breach of confidentially;
(XI) involvement of the applicant or provider involvement in criminal activity or criminal activity in the home;
(XII) failure to complete training per OAC 340:100-3-38;
(XIII) failure of the home to meet standards per subsection (d) of this Section;
(XIV) failure to follow applicable DHS or Oklahoma Health Care Authority (OHCA) rules;

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

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

(f) **Frequency of evaluation.** ~~Homes are assessed for~~ Home profile evaluations are completed for initial approval or denial of an

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

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

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

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

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

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

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

(7) ensures background investigation per OAC 317:40-5-40(b) is repeated every year, except for the OSBI and FBI national criminal history search;
(8) ensures the FBI national criminal history search per OAC 317:40-5-40(b)(4)(A)(ii) is repeated every five years;
(9) includes written notification to providers and agencies, when applicable, of the continued approval of the provider.
(10) includes written notification to providers and agencies, when the provider or agency fails to comply with the home standards per OAC 317:40-5-40 including deadlines for correction of the identified standards; and includes copies of DHS Forms 06AC024E and, when applicable, 06AC010E, in local and State Office records.

(g) Reasons a home profile review may be denied include, but are not limited to:
(1) lack of stable, adequate income to meet the provider's own or total family needs or poor management of available income;
(2) a physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;
(3) the age, health, or any other condition of the provider that impedes the provider's ability to provide appropriate care for a member;
(4) relationship in the provider's household that are unstable and unsatisfactory;
(5)the mental health of the provider or other family or household member impedes the provider's ability to provide appropriate care for a member;
(6) the provider fails to complete required training, or verifications in a timely manner as requested or provides incomplete, inconsistent, or untruthful information;
(7) the home is determined unsuitable for the member;
(8) failure of the provider to complete task related to problem resolution, as agreed, per OAC 340:100-3-27;
(9) failure of the provider to complete a plan of action, as agreed, per OAC 317:40-5-63;
(10) confirmed abuse, neglect, or exploitation of any person;
(11) breach of confidentiality;
(12) involvement of the provider in criminal activity in the home;
(13) failure to provide for the care and well-being of the service member;
(14) failure or continued failure to implement the individual Plan, per OAC 340:100-5-50 through 100-5-58;

(15) failure to complete and maintain training per OAC 340:100-3-38.1;
(16) failure to report changes in the household;
(17) failure to meet standards of the home per subsection (d) of this Section;
(18) failure or continued failure to follow applicable DHS or OHCA rules;
(19) decline of the provider's health to the point he or she can no longer meet the needs of the service member;
(20) employment by the provider without prior approval of the DDS area programs manager for residential services; or
(21) domestic disputes that causes emotional distress to the member.

November 2014 MAC
Proposed Rule Amendment Summaries

Information Only

The following are summaries of proposed rules. These proposals are still in the research stage and are not final. As such, some of the proposals you see here may not advance beyond the research stage. OHCA prepared this document to give members of the MAC a preview of rules, waivers, and state plan revisions. This document is for informational purposes only.

Rule Changes

14-18 Policy Change for State Plan Personal Care services — Rules for the State Plan Personal Care services are amended to match current procedures that are in place at OKDHS. Changes include policy clean up to remove unnecessary language regarding personal care service settings, the criteria for persons eligible to serve as personal care assistants, and minor changes to administration of the State Plan Personal Care services.

14-22 Update to DME Policy — Policy is revised to update Part 17 (Medical Suppliers) in Chapter 30 to clarify rules for durable medical equipment (DME) services. Changes include updating billing and PA requirements for DME items, updating the list of DME items that require a certificate of medical necessity, clarifying that repairs for rental DME items are not covered, and revising the definition of invoice.

14-24 340B Drug Discount Program — The proposed 340B Drug Discount program rule is being added to comply with a federal mandate. The purpose of this rule is to outline special provisions for providers participating in the 340B Drug Discount program. The changes to this program will increase transparency in drug pricing. Changes to the program include aligning reimbursement rates for all drugs closer to the actual price the pharmacy pays for the drug, increasing rebates paid by drug manufacturers, providing rebates for drugs dispensed to SoonerCare members, and lowering reimbursement for certain generic drugs.

14-26 Certified Nursing Aide Training — Certified Nursing Aide (CNA) training rules are amended to discontinue reimbursing schools and instead directly reimburse the students on a pro rata basis for each quarter they are employed in a nursing facility and to change the amount paid.

14-27 Private Duty Nursing — Private Duty Nursing (PDN) rules are amended to reflect initial determination and renewals for services will be determined by an OHCA physician. Additionally, the physician will be responsible for scoring the acuity grid utilized to determine medical necessity. OHCA nurses' responsibility will be to gather, summarize, and present the individual cases to the physicians.

14-28 Allergy Services and Immunotherapy — Rules are amended to add regulations and limitations on allergy services and immunotherapy utilization, current policy has no controls on these services other than medical necessity.

14-29 Pharmacy Lock-in Program — Rules are revised to lock an enrolled member in to a single pharmacy and prescriber rather than a single physician and single provider. As a result, a member is not restricted to one physician; however, the member will be locked into one pharmacy and must receive prescriptions from an identified prescriber. The change will alleviate the administrative burden of having to lock and unlock providers that are not identified as the member's primary care physician.

14-30 Family Planning — The State Plan is revised to remove contraceptive brand name products that are no longer covered. Additionally, language will be updated to align practice to industry standards in regard to time intervals for long-acting reversible contraceptive (LARC) insertion, removal, and reimbursement.

14-31 Cost Sharing —The proposed cost sharing rule is being revised to add smoking and tobacco cessation counseling and products to the exemption for co-payments list. In addition, the proposed change will remove barriers to accessing cessation treatment and may reduce the smoking related morbidity and healthcare cost for SoonerCare members. Further, proposed change may result in increased quit rates and more successful smoking cessation outcomes.

14-33 Policy Change for the Tax Equity Fiscal Responsibility Act Program — Policy is amended to change the Tax Equity Fiscal Responsibility Act (TEFRA) program eligibility rules to match federal guidelines for level of care (LOC). Changes include replacing all TEFRA language regarding mental retardation or ICF/MR to individuals with intellectual disabilities or ICF/IID. Rules regarding ICF/IID LOC eligibility will change to match current DSM-5 and Social Security Act guidelines regarding intellectual disabilities. Specific LOC criteria for determining both hospital and nursing facility will be added to coincide with the ICF/IID criteria. Finally, TEFRA rules will also allow one additional psychological evaluation after the age of six, as medically needed.

14-35 DMEPOS Free Choice — Rules for SoonerCare members' freedom of choice to select their provider of durable medical equipment, prostethics, and orthotics supplies (DMEPOS) are amended to state that providers must inform members of this right when filling or ordering DMEPOS.

14-37 SoonerCare Choice Policy Change — SoonerCare Choice enrollment ineligibility rules are updated to match the Waiver's Special Terms and Conditions. Individuals in the former foster care eligibility group are excluded from participation in SoonerCare Choice; children who are known to be in OKDHS custody are now eligible to participate in SoonerCare Choice.

14-38 Individual Plan of Care — Inpatient psychiatric hospital policy is revised to clarify that the member's signature on the Individual Plan of Care is required at the time of completion.

14-40 Rehab Day Program Progress Note — Policy is revised to clarify that the daily or weekly requirement for progress notes only applies to the psychosocial rehabilitation (PSR) day program. All other PSR/behavioral health rehabilitation services must follow the general progress note guidelines in OAC 317:30-5-248 which require a progress note upon delivery of service/date of service.

14-41 Referrals for Specialty Services — Policy is revised to remove language regarding the inclusion of written referral documentation in members' medical records. The referral will still be captured and maintained in the member record; however, the use of electronic referrals will replace the need of paper documentation.

14-42 Inpatient Psychiatric Hospital — Policy is revised to change the timeframe in which a history and physical (H&P) should be completed in order to comply with federal regulation. The H&P will be completed within 24 hours after admission into an inpatient psychiatric hospital.

14-43 Institutional Transition Case Management — 1915(c) waiver, Medically Fragile policy is revised to clarify the current language within the Institutional Transition Case Management service definition. Currently, the policy is inconsistent with references to Institutional Transition Case Management services and transitional case management services.

14-44 Electronic Notices — OHCA allows electronic notices to be sent to SoonerCare members' designated email addresses. Members may actively select that they wish to receive electronic communications from the agency through the SoonerCare application. The agency will confirm that the member is informed of their right to change this election at any time, ensure that members receive mailed notice of this election, and that all notices are posted on the SoonerCare application for member viewing within one business day. In instances of failed electronic communications, the agency will notify the member, through the mail, of this failed correspondence and that action is necessary.

Urine Drug Screening — The agency implemented limitations on laboratory services due to the overutilization of drug screenings from a max daily amount to a max yearly amount. Based on evidence based research and CMS guidelines on drug screening for members receiving opioid treatment, even a highly susceptible individual should not need more than 3-4 screens a years. Implementing the restrictions would be a cost savings to the agency; no rules were required to implement this change.

Pharmacy Update: Quantity Limit Edit - Short-Acting Painkillers

Burl Beasley, D.Ph, MPH, MS Pharm
Pharmacy Services

Oklahoma HealthCare Authority

TALKING POINTS

- Background
- Quantity Limits – Short Acting Opioids
- Examples
- Timeline
- Summary
- Questions/Comments/Concerns

PAINKILLER PRESCRIBING - BACKGROUND

46

Each day, 46 people die from an overdose of prescription painkillers* in the US. *(17,000 per year)*

259 M

Health care providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills.

10

10 of highest prescribing states for painkillers are in the South.

Source: CDC Vital Signs Opioid Painkiller Prescribing - Where you live makes a difference. July 2014 available at: http://www.cdc.gov/vitalsigns/opioid-prescribing/index.html accessed November 6th 2014.

Source: Prescription Drug Overdose in the United States: Fact Sheet. CDC. Available at: http://www.cdc.gov/homeandrecreationalsafety/overdose/facts.html accessed September 5, 2014

POISONING DEATHS EXCEED MOTOR VEHICLE DEATHS

Unintentional poisoning deaths

- Number of deaths: 36,280
- Deaths per 100,000 population: 11.6

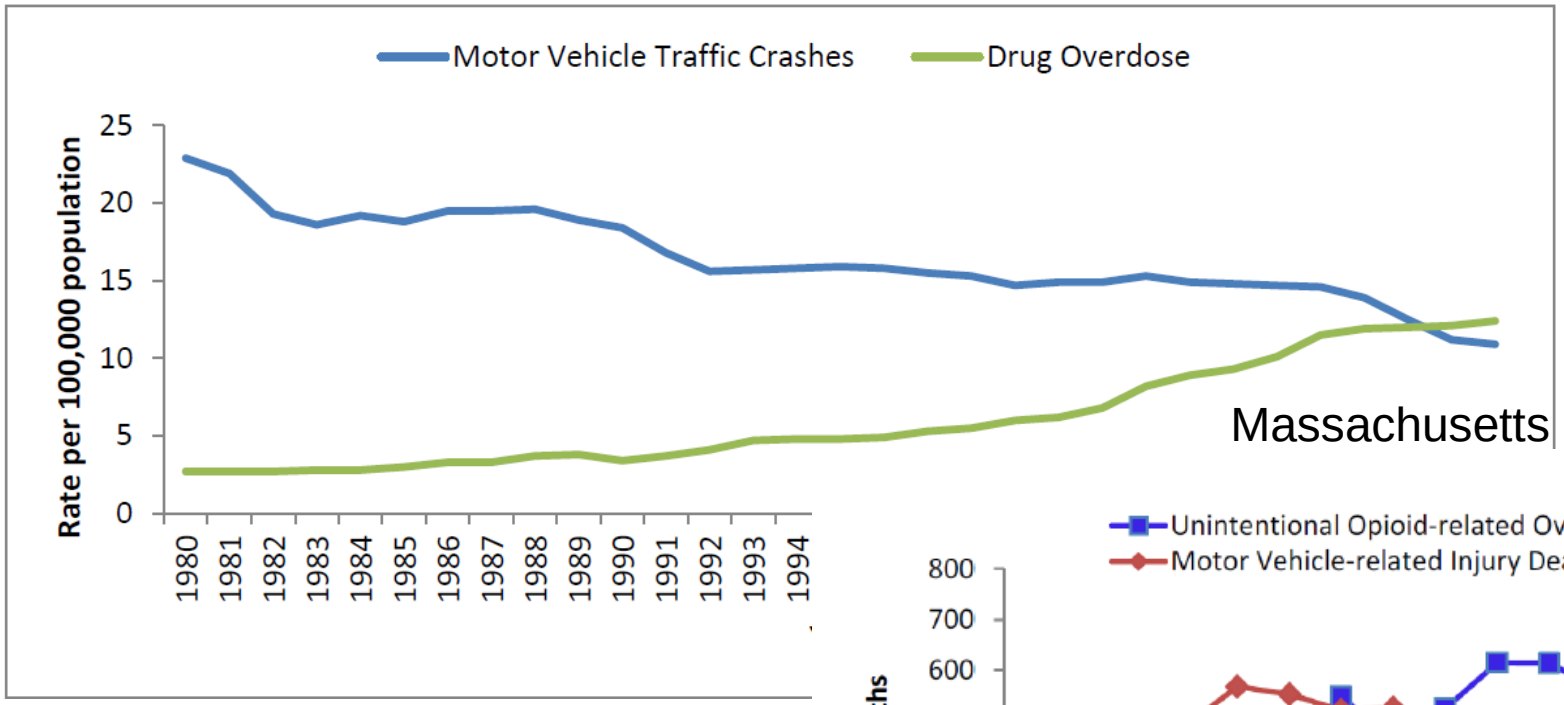
Motor vehicle traffic deaths

- Number of deaths: 33,783
- Deaths per 100,000 population: 10.8

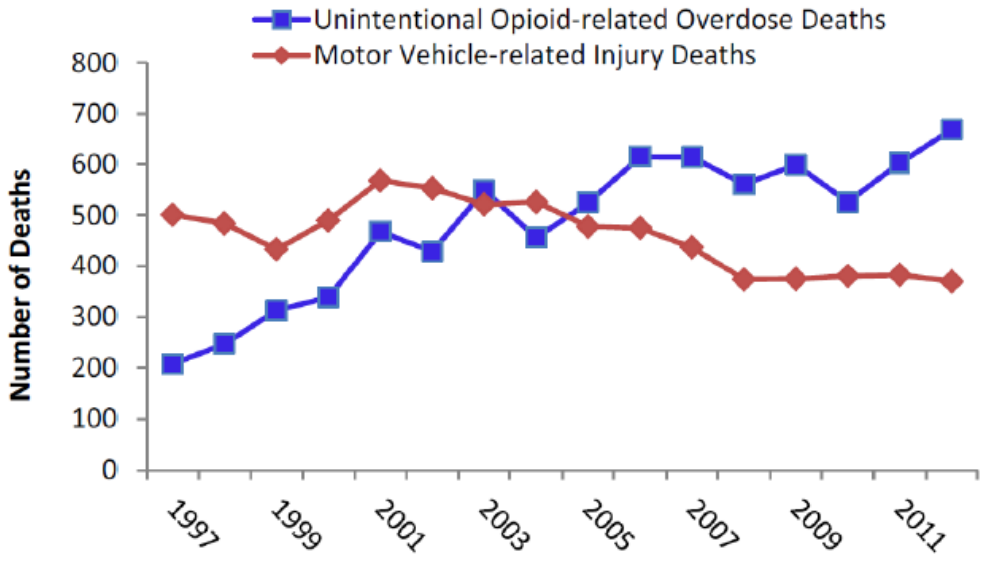
Source: CDC: Accidents or Unintentional Injuries available at: http://www.cdc.gov/nchs/fastats/accidental-injury.htm accessed October 27, 2014.

DRUG OVERDOSE DEATHS VS. MVA DEATH

Figure 1. Rates of motor vehicle traffic and drug overdose deaths, United States, 1980-2010.



Massachusetts

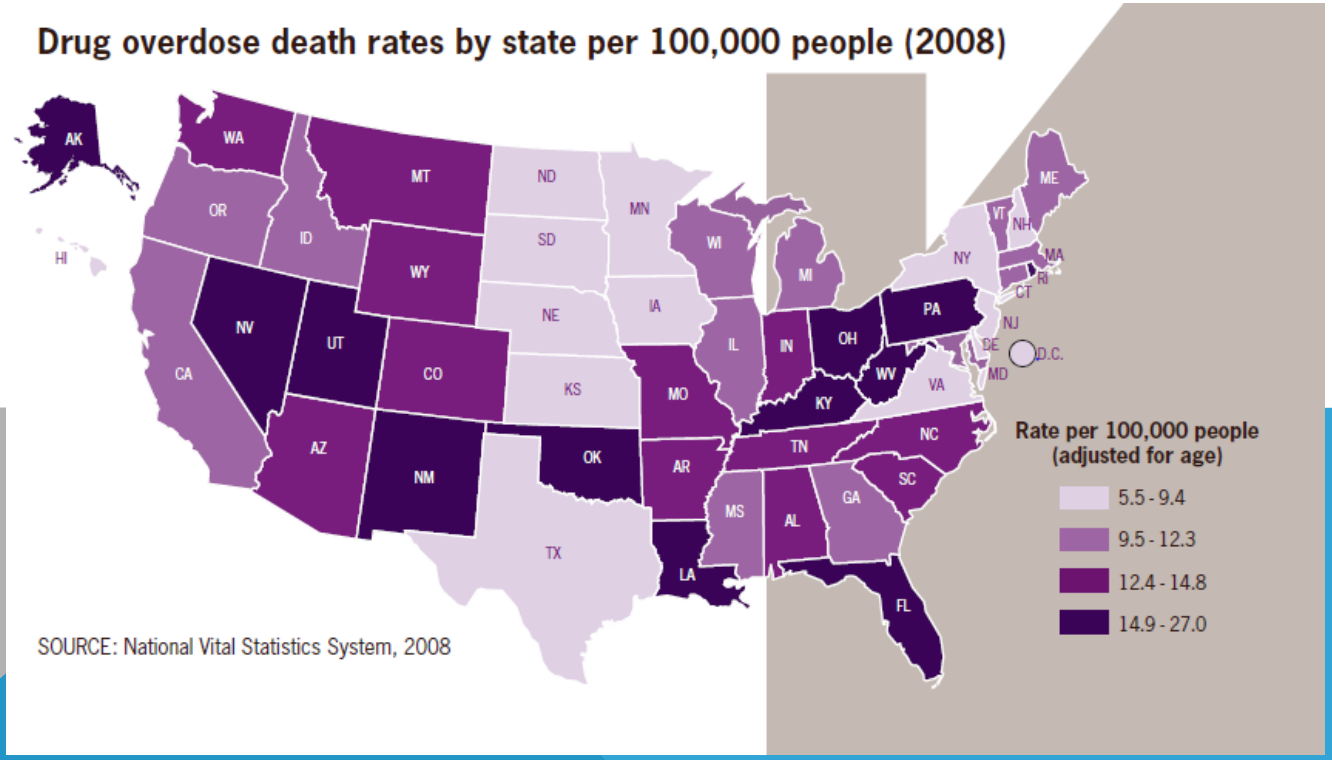


Source: http://www.cdc.gov/HomeandRecreationalSafety/pdf/HHS_Prescription_Drug_Abuse_Report_09.2013.pdf accessed November 3, 2014

PAINKILLER BACKGROUND - OKLAHOMA

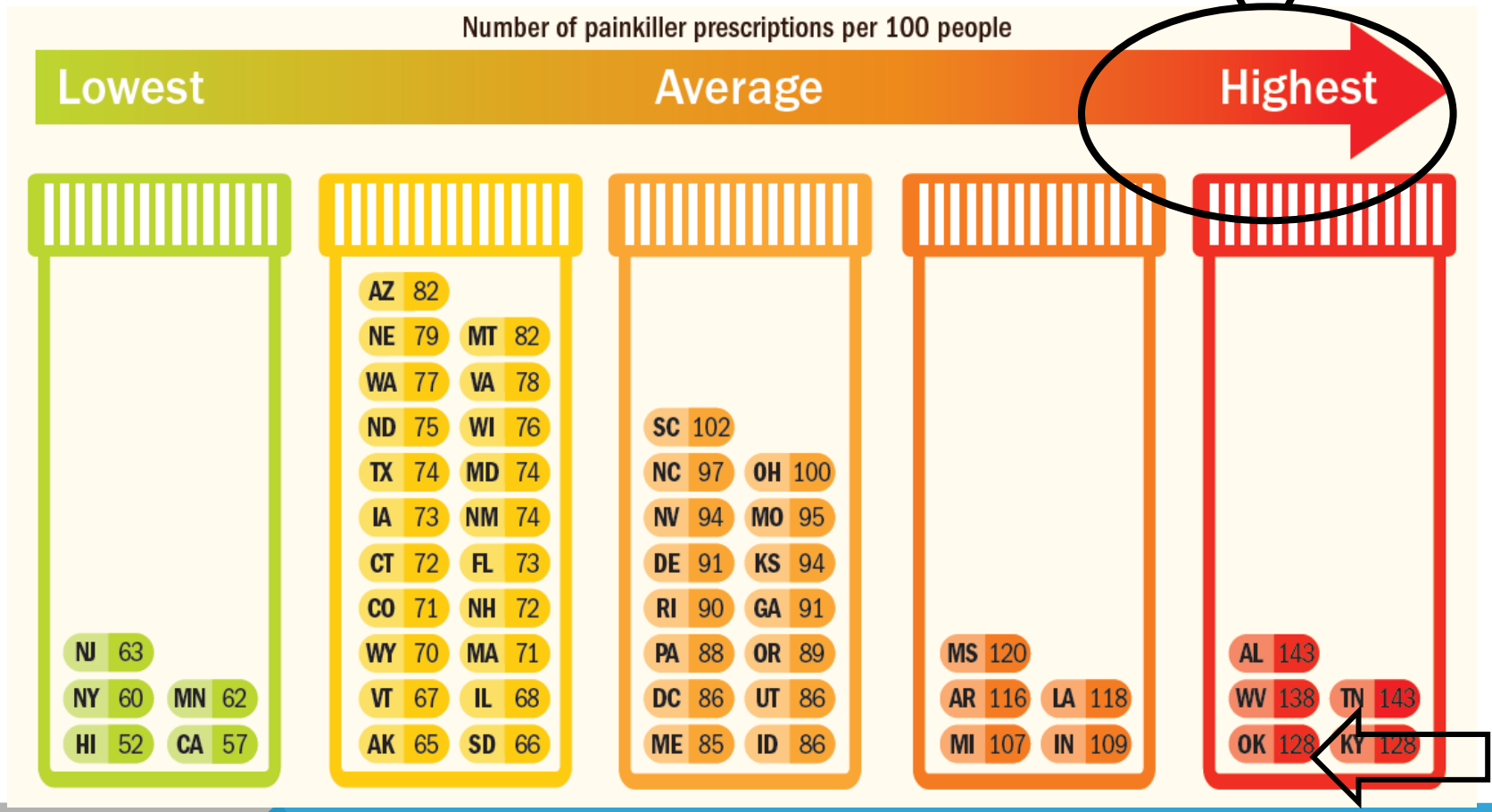
Prescription drug overdose information - Oklahoma

- 15.8% of 100,000 unintentional deaths
- 5th leading cause of death in Oklahoma
- 6th highest drug overdose deaths in U.S.



Source: http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html accessed November 3, 2014

HIGHEST NUMBER OF RXS – OKLAHOMA (5)



Source: CDC Vital Signs Opioid Painkiller Prescribing Where you live makes a difference July 2014 available at: http://www.cdc.gov/vitalsigns/opioid-prescribing/index.html accessed November 6th 2014.

Source: http://newsok.com/oklahoma-ranks-no.-5-in-rate-of-painkillers-prescribed/article/4984477

Source: http://www.cdc.gov/vitalsigns/pdf/2014-07-vitalsigns.pdf July 2014.

REDUCING PRESCRIPTION DRUG ABUSE IN OKLAHOMA 2013

A State Plan

- Governors Initiative
- Broad-based coordination
  - Law Enforcement
  - Prevention and treatment providers
  - Okla. Health Care Agencies
- State Action Items
- Community Action Items

Source:
http://www.ok.gov/odmhsas/documents/Rx%20Abuse%20Prevention%20Plan.pdf
accessed November 3rd 2014

QUANTITY LIMIT EDIT – DRUG EXAMPLES*

Short Acting Pain Killers (all strengths)

- Norco®

  Hydrocodone- Acetaminophen - *Schedule II October 6th***

- Percocet®

  Oxycodone - Acetaminophen

- OxyIR®

  Oxycodone Immediate Release

- MSIR®

  Morphine Immediate Release

*List does NOT include all drug examples
** DEA Publishes Final Rule Rescheduling

Hydrocodone Products available at: http://www.justice.gov/dea/divisions/hq/2014/hq082114.shtml accessed August 22nd 2014.

QUANTITY LIMITS – SHORT ACTING PAINKILLERS

Acute Therapy Quantity Limit

- Allows up to 8 units per day of a short acting opioid for days supply of 10 days or less.

Chronic Therapy quantity limit.

- Allows 4 units per day for day supply of greater than 10 days.
- **OHCA ONLY** -voted on *and* approved DUR Board Feb 2013

Other States and plans may follow (Express Scripts, BCBS, etc)

QUANTITY LIMIT EDITS - EXAMPLE

Acute Therapy Quantity Limit

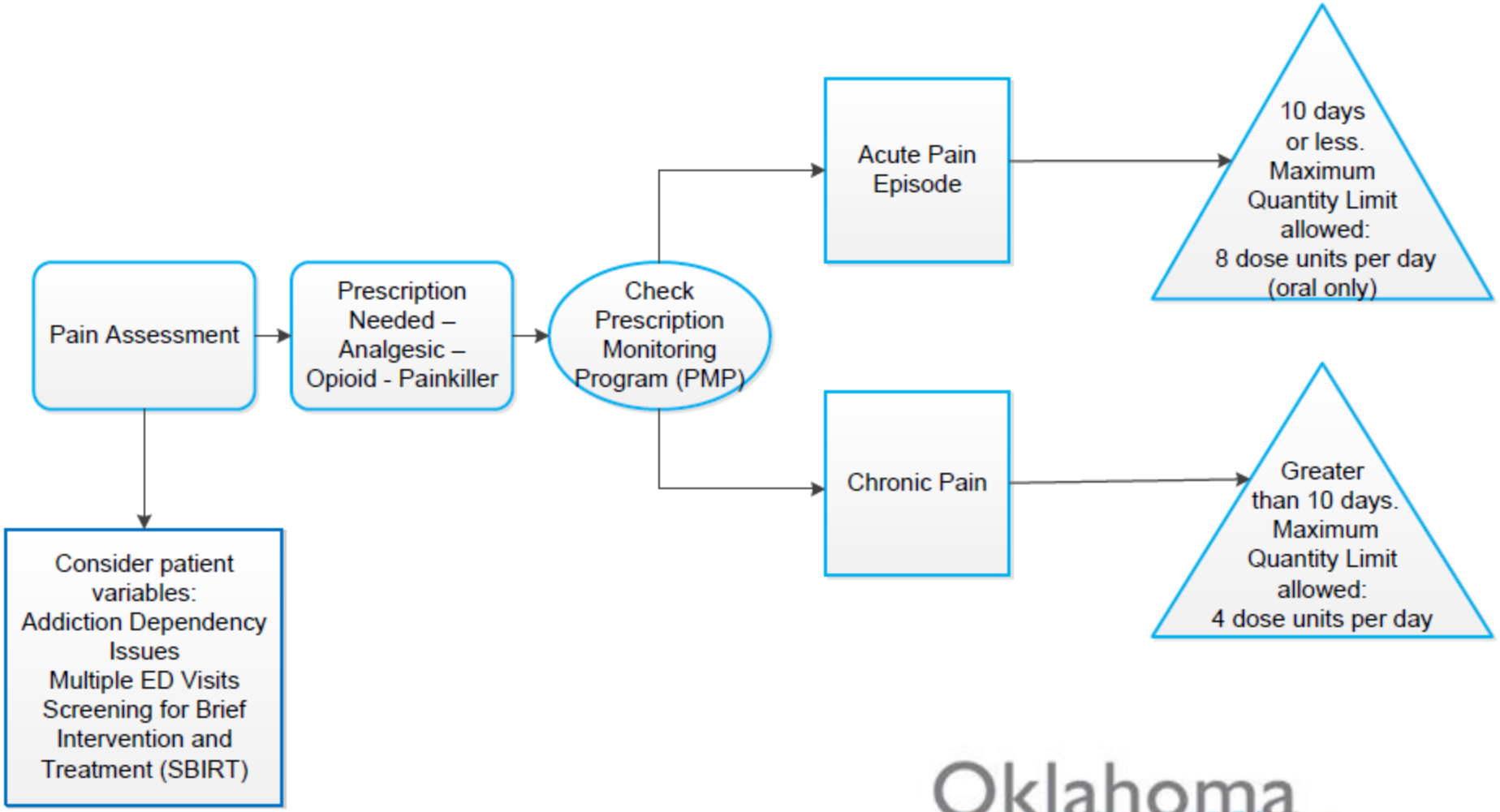
- Allows up to 8 units per day of a short acting opioid for days supply of 10 days *or less*
  - 1-2 tabs q 4-6 hours #120
    - Max reimbursed will be #80 – 8 per day acute therapy

Chronic Therapy quantity limit.

- Allows 4 units per day for day supply of greater than 10 days. For *greater than* 10 days of therapy:
- 1-2 tabs q4-6 hours #240
  - Max reimbursed will be #120 – 4 per day chronic therapy

- **Best Practice Recommendation:**
  - Do NOT use Double Dose Ranges (ie. 1-2, q4-6)

Quantity Limit Edits for Short-Acting Analgesics - Opioids - Painkillers



Short-Acting Opioid Examples:*
Hydrocodone (Norco®),
Oxycodone (Percocet®)
Morphine Sulfate (MSIR®)
Codeine (Tylenol with Codeine®)

ED = Emergency Department
UCC = Urgent Care Clinic
SBIRT = Screen for Brief Intervention and Treatment

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COMMUNICATION PLAN

OHCA

- Press Release – November 3rd
- Provider Letters
- Pharmacy FAX Blasts - October 27th, November 24th

SoonerCare Pharmacy Help Desk

- Prescriber Letters (3) – Member specific
  - October 10th
  - November 14th
  - January 5th 2015

IMPLEMENTATION TIMELINE

Phase I – November 10th 2014

- Hydromorphone (Dilaudid)
- Morphine IR (MSIR®)
- Codeine (Tylenol #3®, Tylenol #4®)

Phase II – December 2014

- Oxycodone IR (Oxy, OxyIR®)
- Oxycodone combination products (Percocet®)

Phase III – January 2015

- Hydrocodone (Norco®, Vicodin®)

MEASURES OF SUCCESS - STATEWIDE

- Decrease in drug seeking behavior from ED
- Decrease in number of painkiller medications available for diversion
- Improve prescriber knowledge of pain management and addiction/treatment
- Improved prescribing practices
- Aligns with State Plan
  - Prescription Drug Abuse Workgroup Goal
- **Decrease in the number of unintentional overdose deaths in Oklahoma**

Stakeholder Survey: Patrick Schlecht & Sarah Coleman

Oklahoma HealthCare Authority

OHCA goal #7 – Collaboration

- **Objective: Measure collaborative efforts**
  - Means: Stakeholder Survey
  - Consultant/Vendor: University of Oklahoma, Department of Family & Preventive Medicine
  - Late 2014/Early 2015 mail & email distribution
  - Report on results in Fall of 2015
  - Ask: MAC review & comment on draft survey
  - Send comments to Sarah-Coleman@ouhsc.edu by November 28th

MEDICAL HOME AUDIT

Update Summary 2015

Oklahoma HealthCare Authority

OVERVIEW

- 2012-2014 MH Audit Report (MRR only)
- 2010-2014 Medical Record Review Measures
- Medical Record Review Measures update
- 2010-2014 Medical Home Measures
- Medical Home Measures update
- 2010-2014 Basic Contract Measures
- Recommendations for 1/1/2015

2012-2014 MEDICAL HOME AUDIT REPORT (MRR)

SFY	Total PCMH Audits	% Passed Medical Record Quality Review
2014	361	97.5%
2013	298	95%
2012	308	91%

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2010-2014 MEDICAL HOME AUDIT MEASURES

Medical Record Review Measures

Tier 1

1. Legibility
2. Authentication
3. Problem List
4. Medication List
5. Allergy Documentation
6. History Content
7. History Authentication
8. Physical Assessment
9. Encounter documentation (e.g. SOAP note)
10. Referral Documentation
11. Ancillary Documentation (Test reports)
12. Preventive Services
13. Patient Education/Instructions
14. Immunization Records
15. Claim Verification
16. Record Organization
17. Medical Home Agreement

2010-2014 MEDICAL HOME AUDIT MEASURES

Medical Record Review

TIER 2 OPT/TIER 3

19. PCP Led Practice (opt-2)
20. Post Visit Follow-Up(opt-2)
21. Evidence Based Clinical Practice Guidelines(opt-2)
22. Medication Reconciliation (Management) (opt-2)
23. Mental Health and Substance Abuse Screening

    (opt-2 - All tiers 2015)

Tier 2/3

18. Care Coordination (transition)

TIER 3

24. Self-management plans
25. Integrated Care Plans (opt)

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MEDICAL RECORD REVIEW MEASURES UPDATE

Weighted medical record review measures

75% of total score to pass MR review.

Points available		Options selected	Points to pass	
TIER 1	100		75.00	
TIER 2	110	No opt.	82.50	
TIER 2	115	1 opt	86.50	
TIER 2	120	2 opt	90.00	
TIER 3	125		93.75	

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MEDICAL RECORD REVIEW MEASURES UPDATE

Tier 1 Weighted MRR – 100 pts.

Legibility	2	Diagnostic tests	5
Authentication	3	Preventive care	15
Problem list	5	Education	5
Med list/review	10	History auth.	2
Allergy doc.	5	Immunization record	2
History Content	5	Claims recon.	3
Physical assess	10	Record org.	3
Encounter doc.	10	Care coordination	5
Referral doc.	5	BH screening	5

MEDICAL RECORD REVIEW MEASURES UPDATE

Tier 2 & 3 required – total points 110

Transition care coordination	10

Tier 2 optional – total points 115-120

PCP led practice	5
Post visit follow up	5

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MEDICAL RECORD REVIEW MEASURES UPDATE

Tier 3 required – total points 125

PCP led practice	5
Post visit follow up	5
Health risk assessment	5

Tier 3 optional – unscored

Integrated care plans	unscored

MEDICAL RECORD REVIEW MEASURES UPDATE

Preventive care performance/tracking criteria

Adults

- Heart health: Blood pressure, Lipid panel, ASA
- Cancer screen: Breast, Cervical, Colorectal
- Annual health risk assess: Tobacco, Obesity, Alcohol
- Sexual health screen: Chlamydia/Gonorrhea
- Immunizations: Flu

MEDICAL RECORD REVIEW MEASURES UPDATE

Preventive care performance/tracking criteria

Child/Adolescent (0-20 years)

- Comprehensive health & development history/assess – nutritional, behavioral, developmental
- Physical Exam/assess – unclothed exam, growth chart, vital signs
- Immunizations
- Labs – lead, H&H, cholesterol
- Health education – age specific anticipatory guidance

MEDICAL RECORD REVIEW MEASURES UPDATE

History Content

- Annual Update
- Must include – medical, surgical, social & family history

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2010-2014 MEDICAL HOME AUDIT MEASURES

Medical Home Measures

Tier 1

1. Care Coordination
2. Referral Tracking
3. Test Tracking
4. Patient Education/Rights
5. Medical Home Agreement
6. Accept Electronic Information from OHCA
7. 24/7 Voice-to-Voice Coverage (optional until March 2012)
8. Open Scheduling (optional until March 2012)

2010-2014 MEDICAL HOME AUDIT MEASURES

Medical Home Measures

TIER 2/3

9. Full-Time Provider
10. Medical Home Patient Tracking

TIER 2 OPT/TIER 3

11. Evidence Based Clinical Practice Guidelines(opt-2)
12. Four Hours of After-Hours Care(opt-2)

TIER 3

13. Health Assessment Tools
14. Health Information Storage (opt)
15. PCP Performance Reporting(opt)

MEDICAL HOME MEASURES UPDATE

Medical home agreement sample

- Single page document
- Bullet statements
- Will be made available on website

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2010-2014 MEDICAL HOME AUDIT MEASURES

Basic Contract Measures

Tier 1-3

1. Provider Licensure
2. Malpractice Coverage
3. Staff Licensure (RN/LPN)
4. Office Hours (posted)
5. Provider/Patient Mix
6. Urgent Appointments
7. Non-Urgent Appointments
8. Provider Availability
9. Coverage
10. EPSDT Outreach/Ed.
11. VFC-OSIIS
12. M.R. Availability
13. CLIA Certificate Current
14. Member Grievance policy

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2010-2014 MEDICAL HOME AUDIT MEASURES

Basic Contract Cont.

Tier 1-3

15. Communicable Diseases policy & training
16. Referral Tracking
17. Care Coordination

Physical Building:

18. Parking
19. Ramp
20. Elevator
21. Wheelchair Accessibility
22. Waiting Room
23. Restrooms (ADA)
24. Examination Rooms
25. Examination Tables
26. Basic Exam Equipment

RECOMMENDATIONS FOR 2015

Notify providers via provider letter, fax blast and on the website:

- Scoring changes: MRR measures now "weighted" rather than each measure having same value
- MH Review and Basic Contract Review are pass/fail - includes all measures (reminder)
- Resources on webpage; i.e. medical home agreement sample
- Call for assistance/education. Call if new staff needs MH education
- Details of update on website; minimum details in provider letter

MEDICAL HOME AUDIT UPDATES

QUESTIONS?

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