Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
September 12th, 2024
1:00 – 3:30 PM
Charles Ed McFall Board Room

AGENDA

Please access via zoom:
https://www.zoomgov.com/webinar/register/WN_cC3tixjYThetPnyd1bwNrw
Telephone: 1-669-254-5252 Webinar ID: 160 254 5252

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Jason Rhynes, O.D.**

II. Action Item: Approval of Minutes of the May 2nd, 2024: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Budget Update: **Tasha Black, Senior Director of Budget and Procurement**

VI. Quality Advisory Committee Update: **Folake Adedeji, Chief Quality Officer**

VII. SoonerSelect Update: **Sandra Puebla, Deputy State Medicaid Director**

- **A.** SoonerSelect Dental Updates: **Bernard Rhone, Director of Dental Services**

VIII. Medicaid Directors Update: **Traylor Rains, State Medicaid Director**

- **A.** Prior Authorization Requirement for Psychological Testing: **Paula Root, Chief Medical Officer**

IX. Proposed Rule Changes: Presentation, Discussion, and Vote: **Kasie McCarty, Senior Director of Federal and State Authorities**

- **A. APA WF #24-22 High-acuity Tracheostomy Rate for Nursing Facilities**
- **B. APA WF #24-23 Applied Behavioral Analysis Policy Revisions**
- **C. APA WF #24-26 A&B Developmental Disabilities Services**
- **D. APA WF #24-20 Pharmacists as Providers**

X. New Business: **Chairman, Jason Rhynes, O.D.**

XI. Future Meeting: **Chairman, Jason Rhynes, O.D.**

November 7, 2024

XII. Adjourn **Chairman, Jason Rhynes, O.D.**

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the March 7, 2024, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions:

Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

Delegates present were: Mr. Nick Barton, Ms. Joni Bruce, Mr. Brett Coble, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Tina Johnson, Ms. Jennifer King, Ms. Melissa Miller, and Dr. Jason Rhynes

Alternates present were: Dr. Eve Switzer Pike providing a quorum.

***Delegates absent without an alternate were*:** Ms. Janet Cizek, Dr. J. Daniel Post Dr. Raymond Smith, and Dr. Whitney Yeates.

II. Approval of the January 4th, 2024 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Ms. Wanda Felty by Ms. Tina Johnson and passed unanimously.

III. Public Comments (2-minute limit):

There were no public comments.

IV. MAC Member Comments/Discussion:

There were no MAC Member comments.

V. Financial Report:

Josh Richards, Senior Director of Financial Services

Mr. Richards presented the financial report ending in November 2023. OHCA is 0.3% over budget in revenues and 0.5 under budget in expenditures with the result that our budget variance is a positive $27,921,334. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 23.4 million state dollars, and administration is a positive 4.4 million state dollars. For more detailed information, see agenda item 5 in the MAC agenda.

VI. Legislative Updates:

Christina Foss, Chief of Staff

Ms. Foss stated that OHCA had their budget hearing with the senate in January. There are a few bills out that we are currently keeping our eye on. SB1417 is a bill that will modernize the way we reimburse nursing facilities. SB1419 will establish a family caregiver model. This will allow our

members who qualify for private duty nursing, to be employed by a home health agency with the proper training to eventually be reimbursed. Finally, SB1703 a requirement from 2022 consolidated appropriations act.

VII. Medicaid Directors Update:

Traylor Rains, State Medicaid Director

Mr. Rains noted that we are currently in open enrollment for Medical, ending March 10th. As of this morning we have about 90,000 members enrolled. If members don't choose a plan by the 10th, then beginning the 11th, we will be auto-assigning which will take a couple of days. As of Monday, in the dental program, we have around 650,000 individuals enrolled. That is up 1,000,00 since it opened. As we ended PHE, we ended with about 276,000 individuals that were un-enrolled and no longer met criteria for eligibility or didn't respond to their renewal requests. However there has been a tremendous volume in renewals and re-applications.

VIII. Proposed Rule Change: Presentation, Discussions, and Vote:

Heather Cox, Federal Authorities Manager

APA WF # 24-03 Collaborative Care Model Reimbursement – The proposed emergency revisions amend rules to comply with state statute at Title 36 Oklahoma Statute § 6060.11a. Senate Bill 444 of the 2023 legislative session directed the agency to implement a "Collaborate Care Model" by requiring reimbursement for behavioral health and substance use disorder services delivered in a primary care setting. The proposed revisions will add "behavioral health integration" as a covered physician's service. The agency is developing medical guidelines that address documentation and limits to ensure proper utilization and billing.

Budget Impact: The estimated budget impact for SFY 2024 will be an increase in the total amount of $127,262; with $41,322 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $1,527,145; with $501,056 in state share.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Joni Bruce and passes unanimously.

APA WF # 24-04 Hospital-Administered Opioid Antagonist Reimbursement – The proposed emergency revisions amend rules to comply with state statute at Title 43A Oklahoma Statute § Section 2-401.2. Senate Bill 712 of the 2023 legislative session directed the agency to reimburse for opioid antagonists separately when provided to members with symptoms of an opioid overdose,

opioid disorder, or any other adverse opioid event related to opioid use in a hospital emergency department.
Budget Impact: The estimated budget impact for SFY 2024 will be an increase in the total amount of $142,203; with $46,173 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $284,406; with $93,314 in state share.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Joni Bruce and passes unanimously.

APA WF # 24-05 Private Duty Nursing (PDN) Coverage Limitations Change – The proposed emergency policy revisions are necessary to protect public health, safety, and/or welfare by providing families and PDN agencies with the flexibility to staff cases according to the family's need and the member's level of care. Revisions will clarify the criteria for virtual visits when a member is assessed for PDN services. Other policy revisions will change the designated care hours from "per day" to "per week". Language will be amended to reflect maximum hours authorized from 16 hours per day to 112 hours per week. Revisions will also add that a member's medical necessity can be determined by an OHCA physician's appointed designee.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Steven Crawford and seconded by Ms. Wanda Felty and passes unanimously.

The proposed **EMERGENCY** rules were presented at the March 5, 2024 Tribal Consultation and were subject to at least a 15-day public comment period.The Agency is requesting the effective date to be immediately upon receiving gubernatorial approval.

APA WF # 24-12 Medication Limits – These emergency revisions are necessary to protect public health, safety, and/or welfare by removing the list of medications exempt from the prescription limits policy, as the list will be hosted on the OHCA website instead. The rule revision and accompanying State Plan amendment are intended to streamline the process of adding new exemptions. New exemptions will be approved by a committee including representatives from Pharmacy and Finance before being posted online.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Joni Bruce and passes unanimously.

IX. MAC Meeting Dates for Calendar 2024:

Chairman, Jason Rhynes, O.D.

July 11, 2024
September 12, 2024
November 7, 2024

X. **New Business:**

Chairman, Jason Rhynes, O.D.

XI. Adjourn:

Chairman, Jason Rhynes, O.D.

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Ms. Tina Johnson and seconded by Ms. Melissa Miller, there was no dissent and the meeting adjourned at 2:10pm.

OKLAHOMA HEALTH CARE AUTHORITY FY 2025 BUDGET

APPROPRIATIONS AND BUDGET

Fiscal Year	Budget	Increase/ Decrease %	Total Appropriation	Increase/ Decrease %	FMAP	Percent Appropriation to Budget
2018	$5,737,712,893	1.0%	$1,018,713,566	3.3%	58.91%	17.8%
2019	$5,928,477,640	3.3%	$1,132,465,946	11.2%	61.43%	19.1%
2020	$6,163,200,792	4.0%	$1,000,039,368	-11.7%	65.11%	16.2%
2021	$6,477,455,224	5.1%	$1,000,039,368	0.0%	67.50%	15.4%
2022	$8,194,267,343	26.5%	$1,194,337,303	19.4%	68.23%	14.6%
2023	$10,066,413,200	22.8%	$1,262,741,642	5.7%	67.60%	12.5%
2024	$10,693,237,573	4.4%	$892,741,642	-29.3%	67.49%	8.3%
2025	$11,195,536,700	4.7%	$1,310,509,100	46.8%	67.19%	11.7%

MEDICAL PROGRAM

Total Budget Increase of $135,143,690 or 1.7%

MEDICAL PROGRAM – GROWTH

Summary of Change	Total Dollar Change
Growth Traditional	$92,310,426
Growth Expansion	$119,947,240
FY 2025 Total Growth	**$212,257,666**

MEDICAL PROGRAM – INITIATIVES

Summary of Change	Total Dollar Change
CRNA Rate Increase	$7,970,533
Nursing Facility Trach Add-On	$2,076,299
FY 2025 Total Initiatives	**$10,046,832**

MEDICAL PROGRAM – STATE AND FEDERAL MANDATES

Summary of Change	Total Dollar Change
State Directed Payments	$404,674,510
Provider Incentive Program	$83,282,853
Continuous Enrollment for Children under age 19	$54,941,044
Mandated Nursing Facility Rate Increase	$101,254,417
Mandated ICF/IID Rate Increase	$9,841,912
Medicare Part D increased premium cost	$12,630,468
FY 2024 Claims Bubble for Delivery System Reform	($359,090,281)
Mandated Pass-through to Hospitals (SB 32X)	($200,000,000)
PHE Unwind (FY 2025 impact)	($174,257,882)
FY 2025 payments to FY 2024 (July Medicare Part A and B)	($20,437,850)
FY 2025 Total Mandates	**($87,160,809)**

MEDICAL PROGRAM – OHCA SUMMARY

Summary of Change	Total Dollar Change
OHCA Growth	$212,257,666
OHCA Initiatives	$10,046,832
OHCA Mandates	($87,160,809)
FY 2025 OHCA Program Total	**$135,143,690**

PROGRAM ASSUMPTIONS

- Enrollment stabilizes at current levels post – PHE unwind
- Normal program growth is estimated at 2.6% overall based on historical utilization
- Soonerselect Capitation payments are included in the analysis and are built based on actuarial developed rates
- Elimination of non-recurring expenses
- Implementation of new and annualization of increased supplemental payment programs

INSURE OKLAHOMA

Total Budget Decrease of ($83,127) or -0.3%

INSURE OKLAHOMA

Percent Change	Program	Total Dollar Change
0.1%	Employer Sponsored Insurance (ESI)	$26,873
-30.6%	Individual Plan (IP)	($110,000)
-0.3%	**FY 2025 Overall Decrease**	**($83,127)**

OHCA ADMINISTRATION

Total Budget Increase of $52,412,594 or 18.7%

OHCA ADMINISTRATION

Percent Change	Division	Total Dollar Change
-2.1%	Operations	($1,341,070)
-11.2%	Contracts (non-IT)	($7,112,030)
0.7%	Insure Oklahoma	$10,414
100%	EGID	$51,751,972
2.1%	Contracts (IT)	$2,925,529
64.8%	Grants Management	$6,177,779
18.7%	**FY 2025 Overall Increase**	**$52,412,594**

OTHER STATE AGENCY PROGRAMS

Total Budget Increase of
$314,825,971 or 13.8%

OTHER STATE AGENCY PROGRAMS

Summary of Change	Total Dollar Change
OHS provider rate increases	$152,247,785
State Directed Payments	$210,473,419
PHE Unwind (FY 2025 impact)	($26,038,534)
FY 2024 Claims Bubble	($21,856,699)
FY 2025 OSA Program Change	**$314,825,971**

REVENUE

Total Budget Increase of $502,299,127 or 4.7%

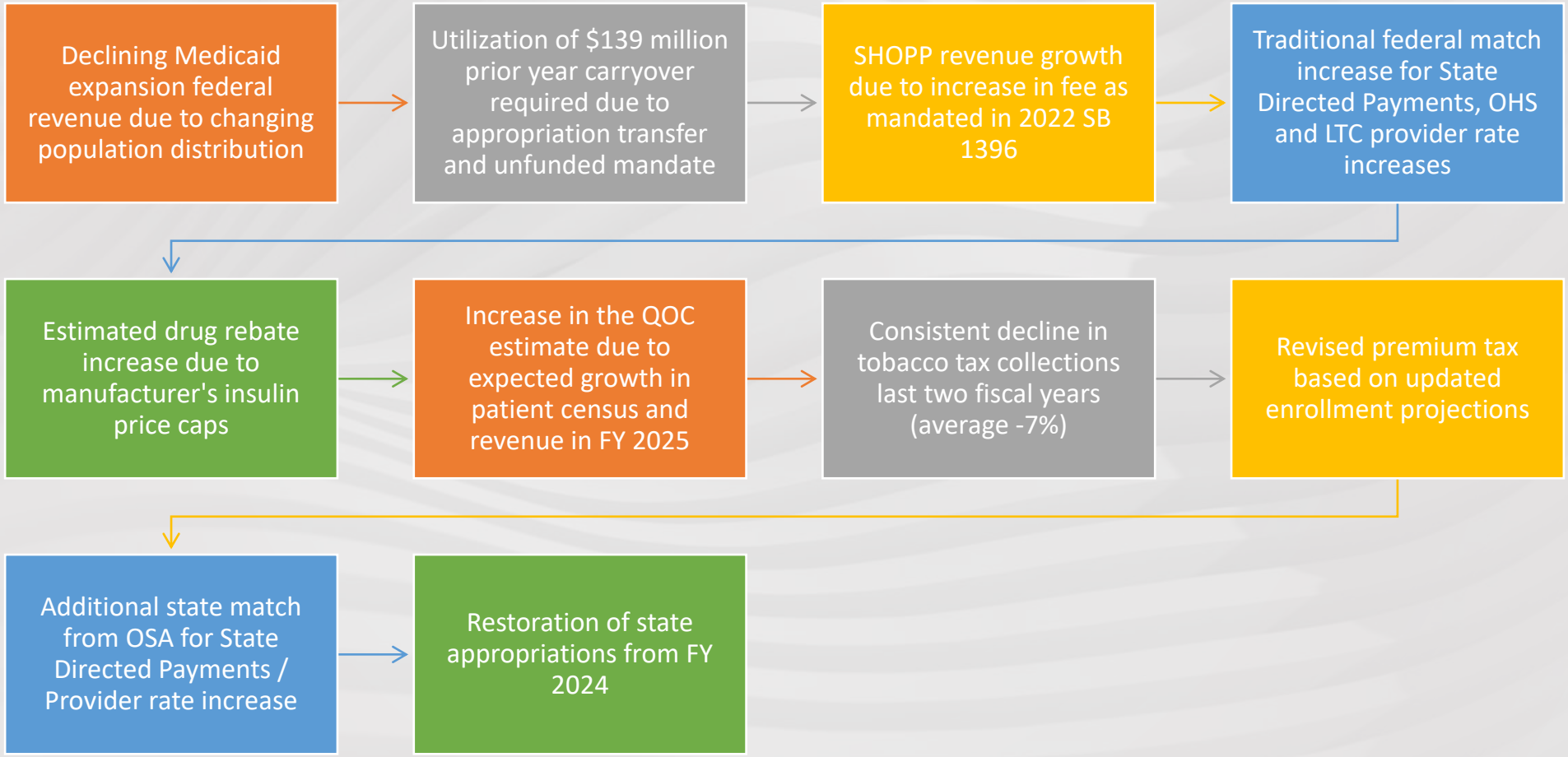
APPROPRIATION SUMMARY

FY 2025 OHCA Appropriation Summary – SB 3837	
SECTION 1 (FY 2025 General Revenue Fund)	$1,096,079,600
SECTION 2 (FY 2023 General Revenue Fund)	$77,000,000
SECTION 3 (FY2025 Health Care Enhancement Fund)	$117,429,500
SECTION 4 (Tobacco Settlement Fund)	$11,000,000
SECTION 5 (Repurposing HIE connection assistance funds)	$9,000,000
FY 2025 Appropriation	**$1,310,509,100**
Section 1 - Transfer to Rate Preservation	**$100,000,000**

REVENUE

Percent Change	Funding Source	Total Dollar Change
11.5%	Federal – Medicaid Traditional	$547,371,723
-12.2%	Federal – Medicaid Expansion	($278,398,190)
7.6%	Federal – Admin	$12,034,640
1.1%	Drug Rebates	$7,903,379
1.6%	Medical Refunds	$815,730
14%	NF Quality of Care Fee	$13,068,454
16.8%	OSA Refunds and Reimbursements	$119,937,049
-11.2%	Tobacco Tax	($9,020,846)
15.8%	Miscellaneous Revenue	$647,359
73.8%	Prior Year Carryover (200)	$22,446,341
-80.4%	Prior Year Carryover (340)	($569,496,666)
-20.1%	Other Grants	($38,720)
12.3%	SHOPP	$41,469,770
100%	EGID	$51,751,972
100%	Premium Tax	$68,901,619
64.9%	State Appropriations	$472,905,515
4.7%	**FY 2025 Overall Increase**	**$502,299,127**

REVENUE ASSUMPTIONS



BUDGET OVERVIEW

SUMMARY

Percent Increase	Expenditures/Revenue	Increase	Total Dollars
4.7%	Expenditures	$502,299,127	$11,195,536,700
4.7%	Revenues	$502,299,127	$11,195,536,700
	Difference		**$0**

KEY TAKEAWAYS

- Administrative spend less than 3% of total spend, including EGID
- OHCA utilizing $139 million fund 340 cash reserve
- FY 2025 Medicaid program growth may be impacted by “boomerang effect”
- Expired enhanced FMAP funds means no surplus of revenue in FY 2025
- OHCA to reserve $100 million in additional savings to the rate preservation fund and by the end of FY 2025 will have savings of almost $600 million

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

okhca.org
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

QUALITY ADVISORY COMMITTEE SUB-COMMITTEES

OHCA Healthcare Quality & Performance

September 12, 2024

QUALITY ADVISORY COMMITTEE (QAC) OVERVIEW

- Established by the Oklahoma Legislature in 2022

Quality Advisory Committee (oklahoma.gov)

- Provide oversight and evaluate performance across all quality-related aspects of SoonerSelect
- Make recommendations to OHCA's Administrator & Board on measures used by contracted entities
- QAC has 19 members appointed by OHCA Administrator
- From its membership, a chair & vice chair have been selected
- Subject to the Oklahoma Open Meeting Act

OVERVIEW

- Meetings are held 2nd Tuesday of every other odd-month @ 1p e.g. September, November etc
- Meetings are open to the public
- The QAC has three sub-committees:
    - Data & Operational Metrics
    - Performance Improvement Projects (PIPs)
    - Primary Care Spend

QAC SUB-COMMITTEE: DATA & OPERATIONAL METRICS UPDATES

Meets every other even-month when the QAC isn't meeting

Six members of the QAC participate in the sub-committee

Three OHCA staff members support the sub-committee

Monitor and evaluate SoonerSelect measures and metrics

Update: The sub-committee is working through what data would be meaningful to add to the dashboard for monitoring and evaluation purposes.

SUB-COMMITTEE: PERFORMANCE IMPROVEMENT PROJECTS UPDATES

Meets 1st Thursday of every other even-month when the QAC isn't meeting

Six members of the QAC participate in the sub-committee

Three OHCA staff members support the sub-committee

Evaluate the PIPs proposed by the medical & CSP plans

Make recommendations to strengthen PIP proposals

Update: Plans have presented their PIPs to sub-committee and the Chair will be making recommendations to the larger QAC group in September

SUB-COMMITTEE: PRIMARY CARE SPEND

- Meets 2nd Monday of every other even-month when the QAC isn't meeting
- Seven members of the QAC participate in the sub-committee
- Three OHCA staff members support the sub-committee
- Define and evaluate what constitutes OHCA's primary care spend
- Make recommendations for OHCA's final primary care spend algorithm
- Update: Plans presented their recommendations of what should be considered as non-claims primary care spend. The sub-committee working through all the recommendations and hopes to arrive at a consensus soon. OHCA staff assigned to sub-committee is meeting with plans 1:1 to discuss $ amounts of some of the plans' recommendations.

QUESTIONS & ANSWERS

OKLAHOMA
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SoonerSelect Dental Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Dental Contract at Section 1.7: Covered Benefits and Section 1.8: Dental Services Utilization Management states that dental contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On July 26, 2024, **DentaQuest** submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the requests.

OHCA decisions are noted in the in the table below:

DentaQuest's Requests to Change Service Provisions		
DENTAL PROCEDURE CODE	**MODIFICATION TO CLAIMS PROCESSING PROTCOL**	**OHCA DECISION**
• **D7230**: Removal of impacted tooth – partially bony	Require prior authorization for D7230. At the time of prior authorization request, require the submission of the following document(s): • Diagnostic quality radiographic image(s) (x-rays) showing the whole soft tissue covered/impacted crown of the teeth in question; • Intra-oral photographs, if available; • Clinical notes; • A comprehensive treatment plan; and • Periodontal charting, if available. **Exception**: Board certified oral surgeons are exempt from this prior authorization requirement but should maintain documentation of medical necessity for any post-payment reviews and/or audits.	Approved for dates of service on or after 10/1/2024
• **D7240**: Removal of impacted tooth – completely bony	Require prior authorization for D7240. At the time of prior authorization request, require the submission of the following document(s): • Diagnostic quality radiographic image(s) (x-rays) showing the whole soft tissue covered/impacted crown of the teeth in question; • Intra-oral photographs, if available; • Clinical notes; • A comprehensive treatment plan; and	Approved for dates of service on or after 10/1/2024

Presented at the September 12, 2024, Medical Advisory Committee meeting

DentaQuest's Requests to Change Service Provisions		
DENTAL PROCEDURE CODE	**MODIFICATION TO CLAIMS PROCESSING PROTCOL**	**OHCA DECISION**
	• Periodontal charting, if available. **Exception**: Board certified oral surgeons are exempt from this prior authorization requirement but should maintain documentation of medical necessity for any post-payment reviews and/or audits.	
• **D7413**: Excision of malignant lesion up to 1.25 cm	At the time of claim submission (pre-payment review) and/or prior authorization request, require the submission of the following document(s): • Pre-operative photographs; • Clinical narrative; and • Any other documentation supporting medical necessity for the service rendered, including but not limited to, intraoperative notes, pertinent radiographs, other imaging and, and a pathology report. Pre-payment review cannot be completed until after pathology report has been received. **Exception**: Board certified oral surgeons are exempt from this pre-payment review but should maintain documentation of medical necessity for any post-payment reviews and/or audits.	Approved for dates of service on or after 10/1/2024
• **D7414**: Excision of malignant lesion greater than 1.25 cm	At the time of claim submission (pre-payment review) and/or prior authorization request, require the submission of the following document(s): • Pre-operative photographs; • Clinical narrative; and • Any other documentation supporting medical necessity for the service rendered, including but not limited to, intraoperative notes, pertinent radiographs, other imaging and, and a pathology report. Pre-payment review cannot be completed until after pathology report has been received. **Exception**: Board certified oral surgeons are exempt from this pre-payment review but should maintain documentation of medical necessity for any post-payment reviews and/or audits.	Approved for dates of service on or after 10/1/2024

SoonerSelect Dental Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Dental Contract at Section 1.7: Covered Benefits and Section 1.8: Dental Services Utilization Management states that dental contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On August 19, 2024, **LIBERTY Dental Plan** submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice, and available data to determine whether to approve the requests.

OHCA decisions are noted in the in the table below:

LIBERTY Dental Plan's Requests to Change Service Provisions		
DENTAL PROCEDURE CODE	**MODIFICATION TO CLAIMS PROCESSING PROTCOL**	**OHCA DECISION**
• **D7220**: Removal of impacted tooth – soft tissue	At the time of claim submission (pre-payment review) and/or prior authorization request, require the submission of the following document(s) when two (2) or more D7220s are rendered on the same date of service: • Diagnostic quality radiographic image(s) (x-rays) showing the whole soft tissue covered/impacted crown of the teeth in question; • Intra-oral photographs, if available; • Clinical notes; • A comprehensive treatment plan; and • Periodontal charting, if available. Down-coding to D7140 is allowable. **Clarification:** OHCA is **not** authorizing pre-payment reviews for a single tooth on a date of service. **Exception**: Board certified oral surgeons are exempt from this pre-payment review but should maintain documentation of medical necessity for any post-payment reviews and/or audits.	Approved for dates of service on or after 10/1/2024
• **D7230**: Removal of impacted tooth – partially bony	Require prior authorization for D7230. At the time of prior authorization request, require the submission of the following document(s):	Approved for dates of service on or after 10/1/2024

Presented at the September 12, 2024, Medical Advisory Committee meeting

LIBERTY Dental Plan's Requests to Change Service Provisions		
DENTAL PROCEDURE CODE	**MODIFICATION TO CLAIMS PROCESSING PROTCOL**	**OHCA DECISION**
	• Diagnostic quality radiographic image(s) (x-rays) showing the whole soft tissue covered/impacted crown of the teeth in question; • Intra-oral photographs, if available; • Clinical notes; • A comprehensive treatment plan; and • Periodontal charting, if available. **Exception**: Board certified oral surgeons are exempt from this prior authorization requirement but should maintain documentation of medical necessity for any post-payment reviews and/or audits.	
• **D7240**: Removal of impacted tooth – completely bony	Require prior authorization for D7240. At the time of prior authorization request, require the submission of the following document(s): • Diagnostic quality radiographic image(s) (x-rays) showing the whole soft tissue covered/impacted crown of the teeth in question; • Intra-oral photographs, if available; • Clinical notes; • A comprehensive treatment plan; and • Periodontal charting, if available. **Exception**: Board certified oral surgeons are exempt from this prior authorization requirement but should maintain documentation of medical necessity for any post-payment reviews and/or audits.	Approved for dates of service on or after 10/1/2024
• **D1354**: Application of caries arresting medicament - per tooth	At the time of claim submission (pre-payment review), require the submission of the following documents when the service is performed on four (4) or more **permanent** teeth on a single date of service: • Diagnostic quality radiographic image(s) (x-rays) showing carious lesion clearly into dentin/past dentoenamel junction (DEJ); • Intra-oral photographs, showing caries and cavitation of tooth/teeth in question to augment/support radiographs, as needed; • Clinical notes; • A comprehensive treatment plan; and • Periodontal charting, if available.	Approved for dates of service on or after 10/1/2024
• **D0601**: Caries risk assessment and documentation, with a finding of low risk • **D0602**: Caries risk assessment and documentation, with a finding of moderate risk	Restrict code to general dentistry practitioners only. If CRA is performed by an orthodontist, the orthodontist will not be reimbursed for the service; however, the CRA may be used as documentation for orthodontic prior authorization requests.	Approved for dates of service on or after 10/1/2024

LIBERTY Dental Plan's Requests to Change Service Provisions		
DENTAL PROCEDURE CODE	**MODIFICATION TO CLAIMS PROCESSING PROTCOL**	**OHCA DECISION**
• **D0603**: Caries risk assessment and documentation, with a finding of high risk		

SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On 1/31/2024, ABH submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the requests.

OHCA decisions are noted in the in the table below:

Presented at the 9/12/2024 Medical Advisory Committee meeting

SoonerSelect Medical Requests to Change Service Provisions

OHCA'S CURRENT PROCESSING PROTOCOL	PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTCOL	REASON FOR PROPOSED MODIFICATION	ANTICIPATED IMAPACT	OHCA DECISION
Cumulative Refill-Too Soon- Edit Logic				
No Cumulative Refill-too-soon logic: only refill-too-soon logic (80% threshold for non-controlled substance)	This request is to add **cumulative** refill too soon logic (i.e., over a 100-day duration of claims history look-back with a 90% threshold) to control for potential FWA, specifically enrollee drug stockpiling effective 10/1/2024. Impacted drugs: This would apply to **all drug classes except transplant meds**	Reduced Potential for Stockpiling: Using only the 80% refill threshold, enrollees could fill a 30-day supply of a medication every 24 days. If the enrollee fills every 24 days for the entire year, then they will have received a 450-day supply of medication (**15 fills**) within a 365-day period. The purpose of the cumulative refill too soon logic is to target and prevent **excessive** stockpiling over the course of the year.	Active proposed **Cumulative** Refill-too-soon logic: 80% refill-too-soon logic PLUS 90% cumulative threshold over 100 days Medication of interest: Non-controlled substance for 30 day supply 30DS*90% = 27 day supply (how soon an enrollee may get a refill) 365 days/27 DS = 13.5 fills → 13 fills; enrollee can get a max of 13 fills over a year when this proposed Cumulative Refill-too-soon logic is active. Compare with: **No Cumulative** Refill-too-soon logic: only has state's refill-too-soon logic (80% threshold for non-controlled substance) Medication of interest: Non-controlled substance for 30 day supply 30DS*80% = 24 day supply (how soon an enrollee may get a refill) 365 days/24 DS = 15.2 fills → 15 fills;	Approved for dates of service on or after 10/01/2024

SoonerSelect Medical Requests to Change Service Provisions				
OHCA'S CURRENT PROCESSING PROTOCOL	**PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTCOL**	**REASON FOR PROPOSED MODIFICATION**	**ANTICIPATED IMAPACT**	**OHCA DECISION**
			enrollee can get a max of 15 fills over a year when only state's refill-too-soon logic is active. Interpretation: An enrollee can potentially receive 2 less medication fills in a 365-day period with the proposed added-on **cumulative** refill-too-soon logic. This is estimated to be approximately 13% (i.e., 2/15 fills) drug cost savings for the plan over the year for an enrollee filling a 30-day supply of specific non-controlled substance. Additionally, the enrollee may potentially save $8 (i.e., $4*2 fills) per medication in drug copay over the year.	

MAC PRESENTATION

Paula Root MD, MPH, MBA

Chief Medical Officer (CMO)

SoonerCare Operations, Medicaid Operations

PRIOR AUTHORIZATION REQUIREMENT FOR PSYCHOLOGICAL TESTING

PRIOR AUTHORIZATION REQUIREMENT FOR PSYCHOLOGICAL TESTING

During an OHCA compliance review for the **Mental Health Parity and Addiction Equity Act (MHPAEA)** it was noted:

- A Prior Authorization (PA) for psychological/neuropsychological test was required for Behavioral Health providers, **however**
- No PA was required for Medical providers

PRIOR AUTHORIZATION REQUIREMENT FOR PSYCHOLOGICAL TESTING

As a result of these findings, OHCA will be adding a PA requirement for psychological testing codes 96130-96139 and 96146 for Medical providers effective 10/1/24.

Guidelines for Medical will closely follow those for Behavioral Health.

PRIOR AUTHORIZATION REQUIREMENT FOR PSYCHOLOGICAL TESTING

General Requirements

Must meet ALL of the following conditions:

- Member is experiencing difficulty in functioning with origins not clearly determined; AND
- An evaluation has been recommended and/or requested by a physician, psychiatrist, psychologist, or a licensed mental health professional; AND
- Results of evaluation will directly impact current treatment strategies.
- If client has been tested recently a different testing battery will be performed.

PRIOR AUTHORIZATION REQUIREMENT FOR PSYCHOLOGICAL TESTING

Documentation Requirements

Documentation requirements must include ALL of the following information:

- What tests will be used?
- How many hours will the testing require?
- Who will be performing the tests, and what are their credentials?
- What is the reason for the testing?
- How will the evaluation results specifically affect goals and objectives for the client?

PRIOR AUTHORIZATION REQUIREMENT FOR PSYCHOLOGICAL TESTING

Psychological/neuropsychological testing codes:

- 96130 – EVALUATION OF PSYCHOLOGICAL TEST BY QHP, FIRST HOUR
- 96131 – EVALUATION OF PSYCHOLOGICAL TEST BY QHP, EACH ADDITIONAL HOUR
- 96132 – EVALUATION OF NEUROPSYCHOLOGICAL TEST BY QHP, FIRST HOUR
- 96133 – EVALUATION OF NEUROPSYCHOLOGICAL TEST BY QHP, EACH ADDITIONAL HOUR

PRIOR AUTHORIZATION REQUIREMENT FOR PSYCHOLOGICAL TESTING

Psychological/neuropsychological testing codes (cont'd):

- 96136 – ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY QHP, FIRST 30 MINUTES
- 96137 – ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY QHP, EACH ADDITIONAL 30 MINUTES
- 96138 – ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY TECHNICIAN, FIRST 30 MINUTES
- 96139 – ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY TECHNICIAN, EACH ADDITIONAL 30 MINUTES
- 96146 – ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY SINGLE STANDARDIZED INSTRUMENT VIA ELECTRONIC PLATFORM WITH AUTOMATED RESULT.

OKLAHOMA
Health Care Authority

GET IN TOUCH

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September 12, 2024 MAC
Proposed Rule Amendment Summaries

These proposed **EMERGENCY** rules were presented at Tribal Consultation and were subject to at least a 15-day public comment period.

The Agency is requesting the effective date to be immediately upon receiving gubernatorial approval.

APA WF #24-22 High-acuity Tracheostomy Rate for Nursing Facilities — The Oklahoma Health Care Authority (OHCA) is proposing a new policy to establish an add-on rate for nursing facilities that serve tracheostomy patients who meet the high-acuity criteria. The rate will help to cover the high cost associated with this type of care and is being determined using existing cost data based on four components: direct care and allied staff costs, social and support staff costs, cost of drugs and medical supplies, and general and administrative costs.

Budget Impact: The estimated budget impact for SFY2025 will be an increase in the total amount of $1,557,225; with $498,468 in state share.

APA WF #24-23 Applied Behavioral Analysis Policy Revisions — The proposed emergency rule revisions update outdated ABA policies to ensure that services meet a standard level of quality for all applicable members. This includes updates to documentation requirements for Behavior Intervention Plans, critical incident reporting, family training requirements, and billing guidelines. Additionally, these rules update the medical necessity criteria and describe various exclusions to treatment. Lastly, language is added to ensure ABA providers do not use restraint, except in extreme and documented circumstances.

Budget Impact: The proposed changes are budget neutral.

APA WF #24-26 A&B Developmental Disabilities Services - The proposed revisions update Developmental Disabilities Services (DDS) policy to align with the DDS 1915(c) Home and Community Based Services (HCBS) waiver programs that were recently amended and approved by the Centers for Medicare and Medicaid Services (CMS), effective July 1, 2024. The proposed revisions add the diagnosis of Global Developmental Delay as an acceptable diagnosis for admission to a DDS HCBS waiver for individuals under 6 years of age and clarify that a diagnosis of intellectual disability (ID) is based on the criteria set forth by the Social Security Administration. Other revisions remove the requirement for authorization of community transition services to be issued for the date a member transitions into the community. Additionally, revisions add a new residential service for members in custody of Oklahoma Department of Human Services (OHS) and adult members with extensive behavioral support needs that cannot be safely met with currently available supports. Lastly, revisions permit legally responsible individuals to serve as Habilitation Training Specialists to individuals for whom they are legally responsible.

Budget Impact: The estimated budget for SFY 2025 will be an increase in the amount of $10,262,939; with $5,717,272 in state share.

The Agency is requesting the effective date to be or November 1, 2024, or upon receiving gubernatorial approval.

APA WF #24-20 Pharmacists as Providers — House Bill 2322 from the 2022 legislative session directed the Oklahoma Health Care Authority to reimburse pharmacists for services rendered within their scope of practice at the same rate paid to other providers for provision of the same services. The proposed additions implement pharmacists' services as a covered benefit to SoonerCare members. The policy additions require pharmacists to be licensed by the Oklahoma State Board of Pharmacy, allows coverage of services within pharmacists' statutory scope of practice, and establishes a reimbursement methodology for pharmacists that is identical to that of physicians. Further, the proposed changes add pharmacists' services to definition of an I/T/U facility encounter, allowing them to be reimbursed at the OMB rate.

Budget Impact: This budget impact is expected to be effectively budget neutral due to a shift in billing provider type; no net increase in utilization or cost is expected.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-133.3. Nursing home ventilator-dependent and tracheostomy care services

(a) Admission is limited to ventilator-dependent and/or ~~qualified~~high-acuity tracheostomy residents.

(b) The ventilator-dependent resident and/or ~~qualified~~high-acuity tracheostomy resident must meet the current nursing facility level of care criteria. (Refer to OAC 317:30-5-123.)

(c) All criteria must be present in order for a resident to be considered ventilator-dependent:

(1) The resident is not able to breathe without a volume with a backup.

(2) The resident must be medically dependent on a ventilator for life support 6 hours per day, seven days per week.

(3) The resident has a tracheostomy.

(4) The resident requires daily respiratory therapy intervention (i.e., oxygen therapy, tracheostomy care, physiotherapy or deep suctioning). These services must be available 24 hours a day.

(5) The resident must be medically stable and not require acute care services. A Registered Nurse or Licensed Practical Nurse must be readily available and have primary responsibility of the unit at all times.

(d) The resident will also be considered ventilator-dependent if all of the above requirements were met at admission but the resident is in the process of being weaned from the ventilator. This excludes residents who are on C-PAP or Bi-PAP devices only.

(e) All criteria must be present in order for a resident to be considered ~~as~~a high-acuity tracheostomy ~~care qualified~~resident:

(1) The resident is not able to breathe without the use of a tracheostomy.

(2) The resident requires daily respiratory therapy intervention (i.e., oxygen therapy, tracheostomy care, chest physiotherapy, or deep suctioning). These services must be available 24 hours a day.

(3) A Registered Nurse or Licensed Practical Nurse must be readily available and have primary responsibility of the unit.

(f) In addition to the requirements in paragraph (e), high-acuity tracheostomy residents will need to meet at least one of the listed criteria below:

(1) The resident has a Brief Interview for Mental Status (BIMS) Interview score between 00-12 (moderately to severely impaired).

(2) The resident sees a pulmonologist monthly and a respiratory therapist at least once every other week, with a respiratory therapist available on call 24 hours a day.

(3) The resident is nonverbal, comatose, or in a vegetative state.

(4) The resident has a contractures diagnosis that results in limited mobility.

(5) The resident requires total dependency from staff with all aspects of daily care.

(6) The resident is unable to suction themselves.

(7) The resident requires tracheostomy deep suctioning at an increased frequency of at least 10 times daily due to thick, copious amounts of secretions.

(8) The resident is unable to clear their own secretions and protect their airway.

(9) The resident has been diagnosed with a progressive neurological disorder that results in muscle weakness; this includes, but is not limited to, Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS), Alzheimer's, head injuries, or Cerebrovascular Accident (CVA).

(10) The resident requires 5 L/min of oxygen or greater than 40% Fraction of Inspired Oxygen (FIO2).

(11) The resident requires breathing treatments that are at an increased frequency of three or more times daily.

(12) The resident has an artificial opening in the neck for the tracheostomy, and an artificial opening in the abdomen for a gastrostomy tube.

(13) The resident has multiple co-morbidities, resulting in demonstrative complications.

(~~f~~g) Not withstanding the foregoing, a ventilator-dependent or ~~qualified~~high-acuity tracheostomy resident who is in the process of being weaned from ventilator dependence or requiring qualified tracheostomy treatment shall continue to be considered a qualified resident until the weaning process is completed.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 30. APPLIED BEHAVIORAL ANALYSIS (ABA) SERVICES

317:30-5-311. Eligible providers and requirements

(a) **Eligible providers.** Eligible ABA provider types include:

(1) Board certified behavior analyst® (BCBA®) - A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc. ® (BACB®) and licensed by the Oklahoma Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board-certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;

(2) Board-certified assistant behavior analyst® (BCaBA®) - A bachelor's level practitioner who are certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;

(3) Registered behavior technician™ (RBT®) - A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services~~;~~. RBTs must obtain ongoing supervision for a minimum of five percent (5%) of the hours they spend providing behavioral-analytic services each calendar month. Documentation may be requested by the OHCA in looking at the progress of treatment.

(4) Licensed psychologist - An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists and has professional experience in the use of ABA therapy may render behavior analysis services. Refer to OAC 317:30-5-275; and

(5) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (G), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;

(D) A licensed speech-language pathologist or licensed audiologist;

(E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;

(F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or

(G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

(b) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.

(1) A BCBA shall:

(A) Be currently licensed by OKDHS DDS as a BCBA;

(B) Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;
(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:
(A) Be currently certified by OKDHS DDS as a BCaBA;
(B) Work under the supervision of a SoonerCare-contracted BCBA provider;
(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(D) Be fully contracted with SoonerCare as a provider.

(3) An RBT shall:
(A) Be currently certified by the national-accrediting BACB as an RBT;
(B) Work under the supervision of a SoonerCare-contracted BCBA provider;
(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(D) Be fully contracted with SoonerCare as a provider.

(4) A human services professional shall:
(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;
(B) Be currently certified by the national-accrediting BACB;
(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;
(D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;
(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(F) Be fully contracted with SoonerCare as a provider.

(5) All contracted providers must reside in the state of Oklahoma, or within 50 miles of the Oklahoma border as per OAC 317:30-3-89 through 92.
(6) All staff providing ABA services must be contracted with the OHCA.

317:30-5-312. Treatment plan components and documentation requirements

(a) **Treatment plan**. The treatment plan is developed by a BCBA or a licensed psychologist from the clinical assessment, and if applicable, the Functional Behavior Assessment (FBA). The treatment plan shall:
(1) Be person-centered and individualized;
(2) Delineate the baseline levels of target behaviors;
(3) Specify long-term and short-term objectives that are defined in observable, measurable behavioral terms;
(4) Specify criteria that will be used to determine achievement of objectives;
(5) ~~Include assessment(s) and treatment protocols for addressing each of the target behaviors such as including antecedent and consequence interventions, and teaching of replacement skills specific to the function of the identified maladaptive behaviors;~~ Clearly relate to the identified maladaptive behavior and/or should include functional goals and those related to

core deficits of ASD as defined by the DSM, both important to and relevant to the child/youth, family, and directly related to the core deficits of ASD as defined by the DSM.

(6) Include specific functional goals to the child/youth, objectively measurable within a specific time frame, attainable in relation to the child/youth prognosis and developmental level.

(7) Include an operational, behavior definition of the target behavior excesses and deficits, prevention and intervention strategies, schedules of reinforcement, and functional alternative responses to the identified function of the target behavior in the BSP.

(8) Include goals that match the setting for services and include a specific titration plan to fade services over time.

~~(6)~~(9) Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed~~;~~.

~~(7)~~(10) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols~~;~~, not to include the functional behavior assessment.

~~(8)~~(11) Include date of training, techniques utilized, and ~~support~~supports used to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan in the home, clinic, ~~and~~ community~~;~~, and other settings.

(12) Include signatures of the BCBA and parent/legal guardian that reflect an actual date including month, day, and year to be considered valid.

(13) Contain the dates of the PA span for which the ABA services have been approved and include the specific date it was created in the treatment plan.

~~(9)~~(14) Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and

~~(10)~~(15) Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

(b) **Assessments and treatment plans.** Initial assessments allow ABA providers to develop a treatment plan that is unique to the member and include all treatment recommendations and goals.

(1) The ~~functional behavior assessment (FBA)~~clinical assessment serves as a critical component of the treatment plan and is conducted by a board-certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The clinical assessment may include validated measures such as the Vineland Adaptive Behavior Scales or other appropriate measures that assist in identifying the child/youth's current skill level, aid in development of the treatment plan, and support medical necessity for ABA services.

(2) The FBA related to specific behaviors of concern, to be addressed in a BSP, as clinically indicated. The FBA consists of:

(A) ~~Description~~An operational definition of the problematic behavior (topography, onset/offset, cycle, intensity, and severity);

(B) History of the problematic behavior (long-term and recent);

(C) Antecedent analysis (setting, people, time of day, and events);

(D) Consequence analysis; and

(E) Impression and analysis of the function of the problematic behavior.

~~(2) Other relevant assessments may be submitted in addition to the FBA for review by an OHCA reviewer and/or physician to support medical necessity criteria.~~

(3) Assessments must be completed by the BCBA.

(c) **Documentation requirements.** ABA providers must:

(1) Document all ABA services in the member's record. Refer to OAC 317:30-5-248;

(2) Retain the member's records necessary to disclose the extent of services. Refer to OAC 317:30-3-15; and

(3) Release the medical information necessary for payment of a claim upon request. Refer to OAC 317:30-3-16.

(4) All assessment and treatment services must include the following:

(A) Date;

(B) Start and stop time for each session/unit billed and physical location where service was provided;

(C) Signature of the ~~provider~~provider(s) rendering services;

(D) Credentials of ~~provider~~provider(s) rendering services;

(E) Specific problem(s), goals, and/or objectives addressed;

(F) Methods used to address problem(s), goals, and objectives;

(G) Progress made toward goals and objectives;

(H) Patient response to the session or intervention; and

(I) Any new problem(s), goals, and/or objectives identified during the session.

(J) ~~Treatment~~ Initial treatment plans or plan updates are not valid until all signatures are present. As used in this subsection, all signatures mean:

(i) The signature and date of acknowledgement of the supervising BCBA or licensed psychologist; and

(ii) The signature and date of ~~assent~~ consent of any minor who is age fourteen (14) or older; and

(iii) The signature of consent of:

(I) A parent or legal guardian of any minor; or

(II) If the minor documents a legal exception to parent or legal guardian consent, the excepted minor.

(iv) All signatures:

(I) Must clearly indicate that the signatories approve of and consent, assent, or acknowledge the treatment plan; and

(II) May be provided on a signature page applicable to both the assessment and the treatment plan, if the signed page clearly indicates approval of and consent, assent, or acknowledgment of both the assessment and the treatment plan.

(III) If member is age fourteen (14) or older and is unable to sign and date documentation, please document this in the record.

317:30-5-313. Medical necessity criteria and covered services for members under twenty-one (21) years of age and frequency and duration

(a) Medical necessity criteria. ABA services are considered medically necessary when all the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers within the state of Oklahoma or within 50 miles of the Oklahoma Border (as per OAC 317:30-3-89 through 92):

(A) Pediatric neurologist or neurologist;

(B) Developmental pediatrician;

(C) Licensed psychologist;
(D) Psychiatrist or neuropsychiatrist; ~~or~~
(E) Other licensed physician experienced in the diagnosis and treatment of ASD~~.~~; or
(F) An interdisciplinary team composed of a licensed psychologist, physician, physician assistant (PA) or nurse practitioner (APRN).

(2) A comprehensive diagnostic evaluation or thorough clinical assessment completed by one (1) of the above identified professionals must:

(A) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and
(B) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.
(C) A comprehensive diagnostic evaluation or clinical assessment will only need to be completed at the first initiation of ABA services and should be no older than two (2) years old. A member does not require an updated assessment or evaluation annually or bi-annually. However, OHCA may request an additional assessment/evaluation if diagnosis and recommendations are not clearly defined.
(D) If a member changes agencies, the comprehensive diagnostic evaluation or clinical assessment will be required during the initial authorization period.
(E) The OHCA may suggest an updated comprehensive evaluation or clinical assessment during the prior authorization process if there are any significant medical, behavioral health changes, or concerns regarding treatment identified through the ABA prior authorization process.
(F) Comprehensive diagnostic evaluations or clinical assessments will only be accepted from an out-of-state provider if the criteria meet documentation requirements outlined in (2)(a)-(c) and must be provided by one of the outlined providers in (1)(a)-(f).

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and
(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).
(5) The member exhibits functional limitations that interfere with participation in daily life and activities that are specific to the core deficits of ASD as outlined in the DSM.
~~(5)~~(6) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities when applicable. Such atypical or disruptive behavior may include, but is not limited to:

(A) ~~Impulsive aggression~~Aggression toward others;
(B) Self-injury behaviors;

(C) Elopement that puts the member at risk in the home and/or community (specific examples of elopement as evidenced by dangerous behaviors, i.e., running out the house, into the parking lot, etc.);

(D) PICA (specific examples of PICA as evidenced by eating non-food items that put the member at risk);

~~(C)~~(E) Intentional property destruction; ~~or~~

~~(D)~~(F) Severe disruption in daily functioning (e.g., the individual's inability to maintain in school, child care settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational therapy, speech therapy, additional psychotherapy and/or school/ daycare interventions~~.~~; or

(G) Excessive self-stimulation that significantly disrupts the individual's ability to engage in functional behavior.

~~(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self-care and self-sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).~~

~~(7) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.~~

(b) Frequency and duration.

(1) ABA may be delivered at the following frequency and duration levels. Medical necessity is related to symptom severity as defined by the current version of the DSM in addition to guidelines in policy. All levels of intensity of ABA treatment services may be considered depending upon individual case consideration. The following are guidelines. The objectives of ABA therapy will vary per child/youth, and frequency and duration should be based upon the functional goals of treatment, specific needs of the child/youth, response to treatment, and availability of appropriately trained and certified ABA staff. The member must have exhibited these atypical or disruptive behaviors within the most recent thirty (30) calendars days that interferes with the daily functioning and activities. Treatment plans in which the requested frequency exceeds the following service level guidelines will be sent for physician and BCBA consultant review to determine medical necessity.

(A) High frequency (IBI) (greater than thirty (30) hours/week) may be considered when both of the following criteria are met.

(i) Autism Severity Level two (2) or three (3) (per most recent DSM criteria), diagnostic evaluation must be included.

(ii) Goals related to elopement, aggression, self injury, intentional property destruction, or severe disruption in daily functioning (e.g., the individual's inability to maintain in school, childcare settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational therapy, speech therapy, additional psychotherapy and/or school/daycare interventions.

(iii) A Functional Behavioral Assessment (FBA) or Behavioral Intervention Plan (BIP) is required for "High Frequency" level of care.

(B) Moderate frequency (twenty (20) to thirty (30) hours/week) may be considered when documentation shows two or more of the following:

(i) Autism Severity Level two (2) or three (3) (per most recent DSM criteria), diagnostic evaluation must be included.

(ii) Goals related to addressing moderate challenging behaviors not generally seen as age or developmentally congruent (e.g., biting for a child over three (3) years old, excessive temper tantrums) that moderately to significantly interfere with child participation in home or community activities.

(iii) A Functional Behavioral Assessment (FBA) or Behavioral Intervention Plan (BIP) is required for "Moderate Frequency" level of care.

(C) Targeted/focused frequency (ten (10) to twenty (20) hours a week) may be considered when documentation shows two or more of the following:

(i) Autism Severity Level one (1), two (2), or three (3) (per most recent DSM criteria); diagnostic evaluation must be included.

(ii) Focused on specific targeted clinical issues or goals related to specific targeted skills.

(D) Maintenance/consultative level (five (5) to ten (10) hours per week or less) may be considered when documentation shows all the following:

(i) Autism Severity Level one (1), two (2), or three (3) (per most recent DSM criteria); and

(ii) Goals related to integration of specific skills into daily functioning and documentation substantiates the risk for regression after completion of more intense ABA intervention.

(E) A Functional Behavioral Assessment (FBA) or Behavioral Intervention Plan (BIP) is not required for "Targeted or Maintenance" level of care.

(F) Members discharging from long term PRTF/Acute two (2) level of care may initially require more intensive treatment.

(2) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self-care and self-sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).

(3) A functional behavioral assessment may only be requested every six (6) months and shall be completed by the licensed provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.

(5) If the member is exhibiting baseline behaviors (behaviors have not improved within a year of attending at least eighty-five percent (85%) of treatment), OHCA may request additional

information to support continued treatment.
(6) Discharge plans will be updated each extension request to include realistic criteria for discharge, based on current progress towards goals.
(7) An OHCA discharge notification form shall be submitted when a member has completed treatment or the member has moved to a new provider, or will no longer be returning to care.

317:30-5-314. Prior authorization, service limitations, and exclusions to treatment
(a) **Prior Authorization.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted ~~up~~by units for one (1) to six (6) months of ABA treatment services as clinically indicated ~~at one (1) time unless a longer duration of treatment is clinically indicated~~. The number of ~~hours~~units authorized may differ from the ~~hours~~units requested on the prior authorization request based on the review by an OHCA reviewer, BCBA contractor, and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The provider is responsible for ensuring eligibility, medical necessity, procedural coding, claims submission, and all other state and federal requirements are met. OHCA retains the final administrative review over both authorization and review of services as required by 42 C.F.R. 431.10. The prior authorization request must meet the following SoonerCare criteria for ABA services.

(1) The criteria should include a comprehensive behavioral assessment, FBA, ~~and other supporting assessment(s)~~BSP (if applicable), treatment plan, and the OHCA initial prior authorization template outlining the maladaptive behaviors or core deficits consistent with the diagnosis of ASD and its associated comorbidities. Additional assessments that may be submitted include the: Stress Index for Parents of Adolescents (SIPA); Assessment of Basic Language and Learning (ABLLS-R); Assessment, Evaluation, and Programming System (AEPS); Verbal Behavior Milestone Assessment and Placement Program (VB-MAPP); and Personalized System of Instruction (PSI.) In addition to completing the initial request form, providers ~~will be~~are required to submit documentation that ~~will consist~~consists of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.
(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.
(C) Direct assessment and observation, including any data related to the identified ~~problem~~maladaptive behavior or core deficits. Clinical history from past trauma should be included, if applicable. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing, and adapting treatment protocols, and evaluating response to treatment and progress towards goals.
(D) Documentation of interviews with parent(s)/caregiver(s) to further identify and define lack of adaptive behaviors and presence of maladaptive behaviors or core deficits.
(E) Length of time that the child/youth has received ABA services as well as previous ABA provider(s).

~~(D)~~(F) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences. Other supporting assessments may be additionally submitted for review.

(G) All treatment plans should be signed and dated by the parent(s)/guardian(s) and child/youth, if applicable.

(H) The OHCA initial prior authorization form must be filled out completely or the request will be considered as incomplete.

(2) The prior authorization request for ABA treatment will be time limited ~~for up to thirty (30) hours per week~~ unless ~~other hours are~~ deemed medically necessary and authorized through a prior authorization request and must:

(A) Be a one-on-one encounter (face-to-face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals that are strengths-specific, family-focused, and community-based;

(C) Be culturally competent and the least intrusive as possible;

(D) Clearly define in measurable and objective terms the intervention plan so it can address specific target behaviors. The intervention plan should be clearly linked to the identified deficits interfering with the child's participation in daily life activities, and if applicable also related to the identified function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the ~~individual~~member.

(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(F) Set quantifiable criteria for progress;

(G) Establish and record behavioral intervention techniques that are appropriate to the identified target and/or maladaptive behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home ~~or other~~, clinic, community, or other natural settings;

(I) Document ~~planning~~plan for transition through the continuum of interventions, services, and settings, as well as discharge criteria. Treatment (behavioral training) will be individualized, and documentation will support the identified skill deficits and atypical or disruptive behavior.

(J) Document the daily schedule by hour and the staff with credentials that will perform each service. If there is a change in staff, identify this in the extension review.

~~(J)~~(K) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings.

Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

~~(K)~~(L) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment. It is expected that child/youth and parent(s)/guardian(s) attend at least eighty-five percent (85%) of treatment each review period, unless due to sickness or other unforeseen circumstances that may occur, to be documented this in the prior authorization request form; and

~~(L)~~(M) Ensure that recommended ABA services do not duplicate, or replicate services received in a member's primary academic education setting or provided within an Individualized Education Program (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

(N) Identify if member is receiving additional therapies such as occupational therapy (OT), physical therapy (PT), or speech therapy and the timeframes in which this occurs, in relation to ABA services.

(b) Service Limitations.

(1) Settings. The following limitations apply to where ABA services are provided:

(A) ABA services are not allowed in a daycare setting or school setting, without OHCA approval. If approved, it will be time-limited to three (3) months or less. The BCBA shall create and submit a treatment plan that identifies the goals outlined to assist school staff with the members without ABA staff being present throughout the school year.

(B) The treatment plan should show a titration of services to school paraprofessionals/staff through the duration of the prior authorization.

(C) If the child/youth is transitioning into a private school, where IEPs are not legally required, then services will be time-limited to three (3) months or less. The BCBA should create and submit an FBA, treatment plan, or BSP, along with the prior authorization request that identifies the goals to match the setting and a specific plan to fade direct support.

(D) ABA treatment may be rendered via in-person service delivery, telehealth, or a hybrid of in-person and telehealth. The modality selected for delivery of ABA services must be clearly defined in the prior authorization template and treatment plan. If services will be provided via telehealth, the ABA provider must provide the justification of how treatment will be beneficial to the member and parents(s)/guardian(s) when rendered this way.

(E) Documentation of services must be maintained, to include: service rendered, location at which service was rendered, and that service was provided via telehealth. Documentation of services must also follow all other SoonerCare documentation requirements.

(2) Coverage. Services are limited to the following:

(A) Providers may only concurrently bill RBT and supervision hours when the following criteria is outlined in the prior authorization request:

(i) The BCBA or licensed psychologist met with the member and/or parent or guardian and directed the RBT through one (1) or more of the following:

(I) Monitoring treatment integrity to ensure satisfactory implementation of

treatment protocols;
(II) Directing RBT staff and/or caregivers in the implementation of new or revised treatment protocols;
(III) Selection and development of treatment goals, protocols, and data collection systems;
(IV) Collaboration with family members and other stakeholders;
(V) Creating materials, gathering materials;
(VI) Reviewing data to adjust treatment protocols; and/or
(VII) Development and oversight of transition and discharge planning.

(B) The BCBA or licensed psychologist used behavior training in session as appropriate in supervision of the RBT staff and/or caregivers. Behavioral skills training consists of providing instructions, modeling, rehearsal, and feedback between provider and member.
(C) The functional behavior assessment is reimbursed per authorized units provided by the BCBA, not to exceed thirty-two (32) units (eight (8) hours).
(D) RBT and supervision codes may be reimbursed for ABA individual treatment.
(E) Parent training may be reimbursed for ABA parent/caregiver/family education and training services. This service must be completed by the BCBA or BCaBA and cannot be completed by the RBT.
(F) ABA is not allowed to be billed concurrently during any other therapies (i.e., OT, PT speech, etc.).
(G) ABA hours approved for one CPT code cannot be used in place of another.
(H) All ABA services should be billed under the rendering provider that performed the services.

(3) Exclusions to Treatment. The following services are non-covered benefits of Oklahoma Medicaid:

(A) ABA addressing academic goals.
(B) ABA addressing goals only related to performative social norms that do not significantly impact health, safety, or independence.
(C) Treatment other than at the maintenance or consultative level not expected to result in improvements in the child/youth's level of functioning.
(D) Services that do not require the supervision of or specific skills and judgement of a BCBA to perform.
(E) Services that do not meet accepted standards of practice for specific and effective treatment of ASD.
(F) Services in the school/daycare setting as a shadow, aide, or to provide general support to the child/youth.
(G) ABA evaluation or intervention services provided by a clinic or agency owned or partially owned by the child/youth's responsible adult (e.g., biological, adoptive, or foster parent(s), guardian(s), court-appointed managing conservator(s), or other family member(s) by birth or marriage).
(H) ABA evaluation or intervention services provided directly by the child/youth's responsible adult (e.g., biological, adoptive, or foster parent(s), guardian(s), court-appointed managing conservator(s), other family member(s) by birth or marriage).
(I) Experimental or investigational treatment.
(J) Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.

(K) Services for the caregiver or provider convenience, for example, as respite care or limiting treatment to a setting chosen by provider for convenience.
(L) ABA authorized for toilet learning/toilet training, OT, or speech therapy.

317:30-5-315. ABA extension requests

Extension requests for ABA services must be submitted to the OHCA or its designated agent.

(1) **Documentation Requirements.** Extension requests must contain the appropriate documentation validating the need for continued treatment and establish and/or document the following:

~~(1)~~(A) Eligibility criteria in OAC 317:30-5-313;
~~(2)~~(B) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;
(C) The daily schedule and staff with credentials that will be performing each service;
(D) Identified positive reinforces and negative reinforcers of targeted behaviors;
(E) A summary of progress towards goals as related to the core deficits and maladaptive behavior identified in the treatment plan;
(F) Updated assessments as appropriate, including an updated, FBA and BIP, updated treatment plan that clearly outlines progress towards goals and any new goals, the OHCA extension prior authorization template outlining the maladaptive behaviors or core deficits consistent with the diagnosis of ASD and its associated comorbidities;

~~(3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;~~
~~(4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);~~
~~(5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;~~
~~(6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and~~
~~(7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.~~

(2) To receive an increase in RBT hours on the first extension request, parent training by the BCBA or BCaBA must be provided at minimum of an hour (1) per week for three (3) months. Start and stop times must be included in the prior authorization request;
(3) Further extension request for an increase in RBT hours will require that parent training has been provided for two (2) hours/week for three (3) months. Start and stop times must be included in the prior authorization request;
(4) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of

parental involvement will be determined by the treatment provider and listed on the treatment plan;
(5) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment.
(6) Absence or less than two (2) hours per month of appropriate parent training/involvement documented in the record will result in a reduction of hours and possibly denial of services;
(7) The OHCA extension prior authorization form must be filled out completely, or the request will be considered as incomplete. A summary of the supported documentation must be included in the prior authorization request;
(8) If problem behavior is persistent outside of clinic, please identify the treatment goals/techniques to address these behaviors in the community, home, or other natural environment;
(9) Document appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);
(10) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorizations;
(11) Identify if member is receiving additional therapies such as occupational therapy (OT), physical therapy (PT), speech therapy, or otherwise and the timeframes in which this occurs, in relation to ABA services;
(12) Extension request may only be submitted seven (7) calendar days prior to the end date of the most recent request. Late submissions may result in a technical denial and loss of days.

317:30-5-316. Reimbursement methodology

SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.
(2) Reimbursement for covered ABA procedure codes is for direct service time. Pre and post work for the session are not reimbursed separately. Separate reimbursement for treatment planning, note documentation, report writing, or updating of charts and data sheet is prohibited (other than what is allowable under the functional behavioral assessment procedure code).
~~(2)~~(3) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. ~~Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.~~
~~(3)~~(4) Reimbursement shall only be made for services that have been prior authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider ~~(~~outlined in OAC 317:30-5-311~~)~~.

~~(4) Providers may only concurrently bill current Procedural Terminology (CPT) codes when they outline in the prior authorization the following criteria:~~

~~(A) The BCBA or licensed psychologist met with the member and/or parent or guardian and directed the RBT through one (1) or more of the following:~~

~~(i) Monitoring treatment integrity to ensure satisfactory implementation of treatment protocols;~~

~~(ii) Directing RBT staff and/or caregivers in the implementation of new or revised treatment protocols;~~

~~(iii) Selection and development of treatment goals, protocols, and data collection systems;~~

~~(iv) Collaboration with family members and other stakeholders;~~

~~(v) Creating materials, gathering materials;~~

~~(vi) Reviewing data to make adjustments to treatment protocols; and/or~~

~~(vii) Development and oversight of transition and discharge planning.~~

~~(B) The BCBA or licensed psychologist used behavior training in session as appropriate in supervision of the RBT staff and/or caregivers. Behavioral skills training consists of providing instructions, modeling, rehearsal, and feedback between provider and member.~~

(5) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

(6) Services rendered via telehealth must be billed using the appropriate modifier.

(7) Reimbursement is in accordance with the prior authorization and coverage limitation requirements within OAC 317:30-5-314.

317:30-5-317. Restraint, Seclusion and Serious Occurrence Reporting Requirements

Physical restraint is not appropriate during any service provided to SoonerCare clients under the Autism Services benefit except in emergency instances of threat of physical harm to the child/youth or others around them. If restraint is used, it may only occur under the following circumstances and according to the processes outlined below.

(1) Physical restraint may only be implemented by a person trained in the type of restraint being implemented. The training must be documented in the personnel file.

(2) Restraint must be limited to the use of such reasonable force as is necessary to address the emergency.

(3) Restraint must be discontinued at the point at which the emergency no longer exists.

(4) Restraint must be implemented in such a way as to protect the health and safety of the child/youth and others.

(5) Restraint must not deprive the child/youth of basic human necessities.

(6) Documentation must be kept of the up-to-date training for all staff members involved and of each incident that resulted in restraint.

(7) Documentation must be kept identifying the reason, start time/end time, the staff signature, and credentials of who performed the restraint, and date.

(8) A phone call to the parent or guardian must be reported immediately if an injury occurs and documented in the record.

(9) In the event of death or serious injury (i.e., bruising, scratches, etc.), the OHCA critical incident reporting form must be submitted to OHCA no later than 5:00 p.m. Central time the

following business day.

317:30-5-318. Service Quality Review

(a) A Service Quality Review (SQR, may be requested by OHCA or it's designated agent).
(b) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses.
(d) The SQR will include, but not be limited to, review of facility and clinical record documentation, staff training, and qualifications. The clinical record review may consist of records of members currently at the facility as well as records of members for which claims have been filed with OHCA for Applied Behavior Analysis. The SQR includes validation of compliance with policy, which must be met for the services to be compensable.
(e) Following the SQR, the SQR team will report its findings in writing to the facility. A copy of the final report will be sent to the Program Integrity, and if applicable any licensing agencies.
(f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental, and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** Payment is made for the Part A coinsurance and deductible for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to members who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for Individuals with Intellectual Disabilities.** Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/IID level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) **Self-care**. The individual requires assistance, training, or supervision to eat, dress, groom, bathe, or use the toilet.

(B) **Understanding and use of language**. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of requests, or is unable to follow two-step instructions.

(C) **Learning**. The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders. <u>When the individual is seeking SoonerCare coverage of Oklahoma Human Services Developmental Disabilities Services HCBS Waivers they must be:</u>

<u>(i) determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or</u>

<u>(ii) Be determined by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) to have a disability and a diagnosis of intellectual disability per SSA guidelines or a diagnosis of global developmental delay when accompanied by a Full-Scale Intelligence Quotient less than or equal to 70, plus or</u>

minus five, when under six (6) years of age as defined in the Diagnostic and Statistical Manual of Mental Disorders

(D) **Mobility**. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) **Self-direction**. The individual is seven (7) years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety, or for legal, financial, habilitative, or residential issues, and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) **Capacity for independent living**. The individual who is seven (7) years old or older and is unable to locate and use a telephone, cross the street safely, or understand that it is unsafe to accept rides, food, or money from strangers. Or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping, or paying bills.

PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, EXTENSIVE RESIDENTIAL SUPPORTS, AND COMMUNITY TRANSITION SERVICES

317:30-5-422. Description of services

Residential supports include:

(1) agency companion services ~~(ACS)~~ per Oklahoma Administrative Code (OAC)317:40-5;

(2) specialized foster care ~~(SFC)~~ per OAC 317:40-5;

(3) daily living supports ~~(DLS)~~:

(A) Community Waiver per OAC 317:40-5-150; and

(B) Homeward Bound Waiver per OAC 317:40-5-153;

(4) group home services provided per OAC 317:40-5-152; ~~and~~

(5) extensive residential supports per OAC 317:40-5-154; and

~~(5)~~(6) community transition services (CTS).

(A) Minimum qualifications. The provider must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide ACS, habilitation training specialist ~~(HTS)~~ services, or DLS, in addition to a contract to provide CTS.

(B) Description of services. CTS is a one-time setup expense for members transitioning from an intermediate care facility for individuals with intellectual disabilities ~~(ICF/IID)~~ or provider-operated residential setting to the member's own home or apartment. The cost per member of CTS cannot exceed limitations set forth by OHCA. The member's name must be on the lease, deed or rental agreement. CTS:

(i) are furnished only when the member is unable to meet such expense and must be documented in the member's Individual Plan (IP);

(ii) include security deposits, essential furnishings, such as major appliances, dining ~~table/chairs,~~tables and chairs, bedroom set, sofa, chair, window coverings, kitchen ~~pots/pans,~~pots and pans, dishes, eating utensils, ~~bed/bath~~bed and bath linens, kitchen dish ~~towel/potholders,~~towels and potholders, a one month supply of laundry/cleaning products, and setup fees or deposits for initiating utility service, including phone, electricity, gas, and water. CTS also includes moving expenses, ~~services/items~~services and items necessary for the member's health and safety, such

as pest eradication, allergen control, a one-time cleaning prior to occupancy, flashlight, smoke detector, carbon monoxide detector, first aid kit, fire extinguisher, and a tempering valve or other anti-scald device when determined by the Personal Support Team necessary to ensure the member's safety; and

(iii) ~~does~~do not include:

(I) recreational items, such as television, cable, satellite, internet, video cassette recorder (VCR), digital video disc (DVD) player, compact disc (CD) player, MP3 player, gaming system, cell phone or computer used primarily as a diversion or recreation;

(II) monthly rental or mortgage expenses;

(III) food;

(IV) personal hygiene items;

(V) disposable items, such as paper ~~plates/napkins,~~plates and napkins, plastic utensils, disposable food storage bags, aluminum foil, and plastic wrap;

(VI) items that are considered decorative, such as rugs, pictures, bread box, canisters, or a clock;

(VII) any item not considered an essential, one-time expense; or

(VIII) regular ongoing utility charges;

(iv) prior approval for exceptions ~~and/or~~and questions regarding eligible items ~~and/or~~and expenditures are directed to the programs manager for community transition services at ~~DHS DDS state office;~~Oklahoma Human Services Developmental Disabilities Services State Office;

~~(v) authorizations are issued for the date a member transitions;~~

~~(vi)~~(v) may only be authorized for members approved for the Community Waiver; and

~~(vii)~~(vi) may not be authorized for items purchased more than ~~30~~thirty (30) calendar days after the date of transition.

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) through Home and Community-Based Services (HCBS).

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

(A) **Minimum qualifications.** Dental services providers must have non-restrictive licensure by the Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

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

(i) Oral examinations;

(ii) Medically necessary images;

(iii) Prophylaxis;

(iv) Fluoride application;

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

(I) Pain elimination;

(II) Adequate oral hygiene; and

(III) Restoring or improving ability to chew;

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

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

(C) **Coverage limitations.** Dental service coverage is specified in the member's Individual Plan (IP) in accordance with applicable Waiver limits. Cosmetic dental services are not authorized.

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

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants have current, non-restrictive licensure by the Oklahoma Board of Medical Licensure and Supervision. Occupational therapy assistants are supervised by occupational therapists, per OAC 317:30-5-295 (b) (1).

(B) **Service description.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, mealtime assistance, assistive technology, positioning, and mobility. Occupational therapy services may include occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:

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

(II) Rendered in any community setting as specified in the member's IP. The IP includes a practitioner's prescription.

(ii) For this Section's purposes, a practitioner means medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) Service provision includes a written report or record documentation in the member's record, as required.

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

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma Board of Medical Licensure and Supervision. The physical therapist supervises the physical therapist assistant, per OAC 317:30-5-290.1 (b) (1).

(B) **Service description.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility skeletal and muscular conditioning, assistive

technology, and positioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(ii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in fifteen-minute (15-minute) units with a limit of four hundred and eighty (480) units per POC. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification to provide psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists, or by the licensing board in the state where the service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Service description.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider develops, implements, evaluates, and revises the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

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

(II) Provided in individual and group formats, with a six-person maximum.

(ii) Service approval is based on assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) Payment is made in fifteen (15) minute units. A minimum of fifteen (15) minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed twelve (12) months.

(I) Initial authorization does not exceed one hundred and ninety-two (192) units, forty-eight (48) service hours.

(II) Authorizations may not exceed two hundred and eighty-eight (288) units per POC year unless the DDS Behavior Support Services director or designee makes an exception.

(III) No more than twelve (12) hours of services, forty-eight (48) units, may be billed for PIP preparation. Any clinical document is prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one (1) revision. The time for preparing the revision is clearly documented and does not exceed four (4) hours.

(6) **Psychiatric services.**

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

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

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

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

(C) **Coverage limitations.** A unit is thirty (30) minutes, with a limit of two hundred (200) units, per POC year.

(7) **Speech-language pathology services.**

(A) **Minimum qualifications.** Qualification as a speech-language pathology services provider requires current, non-restrictive licensure as a speech-language pathologist, speech-language pathology assistant, or speech-language pathology clinical fellow, by the Oklahoma Board of Examiners for Speech-Language Pathology and Audiology, per OAC 317:30-5-675.

(B) **Service description.** Speech therapy includes evaluation, treatment, and consultation in communication, oral motor activities, and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting specified in the member's IP.

(i) The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech or language services or both in accordance with rules and regulations covering the OHCA SoonerCare program.

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

(C) **Coverage limitations.** A unit is fifteen (15) minutes, with a limit of two hundred and eighty-eight (288) units, per POC. Payment is not allowed solely for written reports or record documentation.

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

(A) **Minimum qualifications.** Providers complete Oklahoma Human Services (OKDHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) Are at least eighteen (18) years of age or older;

(ii) Are specifically trained to meet members' unique needs;

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

(iv) Receive supervision and oversight from contracted-agency staff with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

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

(i) Payment is not made for~~:~~ routine care and supervision family normally provides.

~~(I) Routine care and supervision family normally provides; or~~

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

(ii) Family members who provide HTS services meet the same standards as providers who are unrelated to the member. Legally responsible individuals, per OAC 340:100-3-33.2, may provide HTS for extraordinary care as determined by the Oklahoma Choice Assessment completed annually by DDS staff. HTS staff residing in the same household as the member may not provide services in excess of forty (40) hours per week. Members who require HTS services for more than forty (40) hours per week use staff members who do not reside in the household, and who are employed by the member's chosen provider agency, to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

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

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

(v) Review and approval by the DDS plan of care reviewer is required.

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

(I) Provider receives DDS area staff oversight; and

(II) Is pre-approved by the DDS director or his or her designee.

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

(i) A unit is fifteen (15) minutes.

(ii) Individual HTS service providers are limited to a maximum of forty (40) hours per week regardless of the number of members served.

(iii) More than one (1) HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two (2) or more HTSs to the same member during the same hours of a day.

(v) An HTS may receive reimbursement for providing services to only one (1) member at any given time. This does not preclude services from being provided in a group setting where services are shared among group members.

(vi) HTS providers may not perform any job duties associated with other

employment including on-call duties, at the same time they are providing HTS services.

(9) **Remote Supports (RS).** RS is provided per OAC 317:40-4-4.

(10) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(11) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(12) **Audiology services.**

(A) **Minimum qualifications.** Audiologists have licensure as an audiologist by the Oklahoma Board of Examiners for Speech Pathology and Audiology per OAC 317:30-5-675 (d) (1).

(B) **Service description.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities.

(i) The member's IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with OAC 317:30-5-1 covering the OHCA SoonerCare program.

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

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

(13) **Prevocational services.**

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

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

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

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are learning and work experiences where the member can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

(ii) Activities include teaching concepts such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered to further habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation is maintained in the record of each member receiving this service, noting the service is not otherwise available

through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) Services include:

(I) Center-based prevocational services, per OAC 317:40-7-6;

(II) Community-based prevocational services per, OAC 317:40-7-5;

(III) Enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) Supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed the annual costs set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. The services that may not be provided to the same member at the same time as prevocational services are:

(i) HTS;

(ii) IPS;

(iii) Adult Day Health;

(iv) Daily Living Supports (DLS);

(v) Homemaker; or

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

(14) **Supported employment.**

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

(i) Are eighteen (18) years of age or older;

(ii) Complete the OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.5; and

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Services description.** For members receiving HCBS Waiver services, supported employment is conducted in various settings, particularly worksites where persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work, including supervision and training. The supported employment outcome is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level the employer pays for the same or similar work individuals without disabilities perform. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

(i) When supported-employment services are provided at a worksite where persons without disabilities are employed, payment:

(I) Is made for the adaptations, supervision, and training members require as a result of their disabilities; and

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

(ii) Services include:

(I) Job coaching per OAC 317:40-7-7;

(II) Enhanced job coaching per OAC 317:40-7-12;

(III) Employment training specialist services per OAC 317:40-7-8; and

(IV) Stabilization per OAC 317:40-7-11.

(iii) Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA is maintained in each member's record.

(v) Federal financial participation may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) Payments passed through to users of supported-employment programs; or

(III) Payments for vocational training not directly related to a member's supported-employment program.

(C) **Coverage limitations.** A unit is fifteen (15) minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported-employment services combined cannot exceed $27,000, per POC year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The services that may not be provided to the same member, at the same time as supported-employment services are:

(i) HTS;

(ii) IPS;

(iii) Adult Day Health;

(iv) DLS;

(v) Homemaker; or

(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(15) **IPS.**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and OKDHS DDS. Providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

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

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities; and

(v) Receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Service description.**

(i) IPS:

(I) Are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) Build on the support level HTS or DLS staff provides by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational and habilitation activities.

(ii) The member's IP clearly specifies the role of HTS and the person providing IPS to ensure there is no service duplication.

(iii) The DDS POC reviewer is required to review and approve services.

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

(16) **Adult day health.**

(A) **Minimum qualifications.** Adult day health provider agencies:

(i) Meet licensing requirements, per 63 O.S. § 1-873 *et seq*. and comply with OAC 310:605; and

(ii) Are approved by the OKDHS DDS director and have a valid OHCA contract for adult day health.

(B) **Service description.** Adult day health provide assistance with retaining or improving the member's self-help ability adaptive and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting away from the home or facility where the member resides.

(C) **Coverage limitations.** adult day health is furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. A unit is fifteen (15) minutes for up to a maximum of eight (8) hours daily. All services are authorized in the member's IP.

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.** This Section applies to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and Section 1915(c) of the Social Security Act. Specific Waivers are the In-Home Supports Waiver (IHSW) for Adults, IHSW for Children, Community Waiver, and Homeward Bound Waiver.

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

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

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

(3) Choosing between services provided through an HCBS Waiver or institutional care; and

(4) Reporting any changes in address or other contact information to OKDHS within thirty (30) calendar days.

(c) **Waiver eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in (1) of this Subsection and the criteria for one (1) of the Waivers established in (1) through (8) of this Subsection.

(1) **HCBS Waiver services.** Services provided through an HCBS Waiver are available to Oklahoma residents meeting SoonerCare (Medicaid) eligibility requirements established by law, regulatory authority, and policy within funding available through state or federal resources. To be eligible and receive services funded through any of the Waivers listed in (a) of this Section, an applicant must meet conditions, per OAC 317:35-9-5. The applicant:

(A) Must be determined financially eligible for SoonerCare, per OAC 317:35-9-68;

(B) 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, or residential care home per Section (') 1-820 of Title 63 of the Oklahoma Statutes (O.S.), or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID);

(C) May not be receiving 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; and

(D) Must also meet other Waiver-specific eligibility criteria.

(2) **In-Home Supports Waivers (IHSW).** To be eligible for services funded through the IHSW, an applicant must:

(A) Meet all criteria listed in (c) of this Section; and

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

(C) Be determined by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) to have a disability and a diagnosis of intellectual disability per SSA guidelines or a diagnosis of global developmental delay when accompanied by a Full-Scale Intelligence Quotient (FSIQ) less than or equal to seventy (70), plus or minus five (5), when under six (6) years of age as defined in the Diagnostic and Statistical Manual of Mental Disorders ~~by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU)~~; and

(D) Be three (3) years of age or older;

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

(F) Reside in:

(i) A family member's or friend's home;

(ii) His or her own home;

(iii) An OKDHS Child Welfare Services (CWS) foster home; or

(iv) A CWS group home; and

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

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

(A) Meet all criteria listed in (c) of this Section;

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

(C) Have an intellectual ~~disability as defined in the Diagnostic and Statistical Manual of Mental Disorders~~per SSA guidelines or a related condition by DDS and be covered under the State's alternative disposition plan, adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(D) Be determined by the OHCA LOCEU to have a disability and a diagnosis of intellectual disability per SSA guidelines or a diagnosis of global developmental delay when accompanied by an FSIQ less than or equal to seventy (70), plus or minus five (5), when under six (6) years of age as defined in the Diagnostic and Statistical Manual of Mental Disorders ~~or the OHCA LOCEU~~; and

(E) Be three (3) years of age or older; and

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

(G) 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 DDS director or designee.

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

(A) 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;

(B) Meet all criteria for HCBS Waiver services listed in (c) of this Section; and

(C) Be determined by SSA to have a disability and a diagnosis of intellectual disability; or

(D) 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 as determined by 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

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

(F) Meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122, as determined by the OHCA LOCEU.

(5) **Evaluations and information.** Applicants desiring services through any of the Waivers listed in (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 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 sixteen (16) years of age and older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between seven to sixteen (7 to 16) years of age are considered current for four (4) years when the full-scale intelligence quotient is less than forty (40) and for two (2) years when the intelligence quotient is forty (40) or above.

(II) When an applicant is approved for an HCBS waiver with a diagnosis of global developmental delay, a new psychological evaluation must be conducted and submitted after the child reaches six (6) years of age. Re-evaluation occurs at the beginning of the plan of care year following the child's sixth (6^{th}) birthday, at which time, a diagnosis of Intellectual Disability must be confirmed to continue waiver services.

~~(II)~~(III) 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 twelve (12) months of the requested approval date that includes a developmental history; and

(C) A medical evaluation, current within one (1) calendar year of the requested approval date; and

(D) A completed Form LTC-300, ICF/IID Level of Care Assessment; and

(E) Proof of disability per SSA guidelines. When a disability determination is not made by SSA, OHCA LOCEU may make a disability determination using SSA guidelines.

(6) **Eligibility determination.** OHCA reviews the diagnostic reports listed in (2) of this subsection and makes an eligibility determination for DDS HCBS Waivers.

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

(8) **Member's choice.** A determination of need for 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 DDS resources are unavailable to add individuals to services funded through 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. The applicant must submit the required documentation, per Form 06MP001E, Request for Developmental Disabilities Services, for initial consideration of potential eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list with the date they applied in the other state. The person's name is added to the list when he or she provides proof of application date from the other state.

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

(3) An individual applicant is removed from the Request for Waiver Services List, when he or she:

(A) Is found to be ineligible for services;

(B) Cannot be located by OKDHS;

(C) Does not provide OKDHS-requested information or fails to respond;

(D) Is not an Oklahoma resident at the requested Waiver approval date; or

(E) Declines an offer of Waiver services.

(4) An applicant removed from the Request for Waiver Services List, because he or she could not be located, may submit a written request to be reinstated to the list. The applicant is returned to the same chronological place on the Request for Waiver Services List, provided he or she was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within forty-five (45) calendar days. When action is not taken within the required forty-five (45) calendar days, the applicant may seek resolution, per OAC 340:2-5-61.

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

(2) When requested information is not provided within sixty (60) calendar days, the applicant is notified that the request was denied, and he or she is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List, per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, per (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, 43A O.S. § 10-103:

(I) Is hospitalized;
(II) Moved into a nursing facility;
(III) Is permanently incapacitated; or
(IV) 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) OKDHS finds the person needs protective services due to 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, when 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 appropriated special funds with which to serve a specific group or a specific class of individuals, per HCBS Waiver provisions;

(3) Waiver services may be required for people who transition to the community from a public ICF/IID or children in OKDHS custody receiving services from OKDHS. 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/IID and enters the Waiver; or

(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 are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted per Title 42 Section 483.100 of the Federal Code of Regulations 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, and choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between DDS HCBS Waiver programs.** A person's movement from services funded through one (1) DDS-administered HCBS Waiver to services funded through another DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes eighteen (18) years of age, services through the IHSW for adults becomes 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 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 was within the IHSW per capita allowance.

(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 was not 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 the level of care, per OAC 317:30-5-122, and confirms a diagnosis of intellectual disability per ~~the Diagnostic and Statistical Manual of Mental Disorders.~~SSA guidelines.

(1) DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.

(2) Annual review of eligibility requires a medical evaluation that is current within one year of the requested approval date. The medical evaluation must be submitted by the member or the individual acting on his or her behalf thirty (30) calendar days prior to the Plan of Care expiration.

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

(1) A member or the individual acting on the member's behalf chooses to no longer receive Waiver services;

(2) A member is incarcerated;

(3) A member is financially ineligible to receive Waiver services;

(4) A member is determined by SSA to no longer have a disability qualifying the individual for services under these Waivers;

(5) A member is determined by the OHCA LOCEU to no longer be eligible;

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

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

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

(9) The guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of the OKDHS rule 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 were not effective;

(10) The member is determined to no longer be SoonerCare eligible;

(11) There is sufficient evidence the member or the individual acting on the member's behalf 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) The member or the individual acting on the member's behalf either cannot be located, did not respond, or did not allow case management to complete plan development or monitoring activities as required, per OAC 340:100-3-27, and the member or the individual acting on the member's behalf:

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

(B) The response prohibits the case manager from being able to complete plan development or monitoring activities as required, per OAC 340:100-3-27;

(13) The member or the individual acting on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;

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

(15) The member or the individual acting on the member's behalf fails to cooperate with service delivery;

(16) A family member, 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 OKDHS representatives; or

(17) A member no longer receives a minimum of one (1) Waiver service per month and DDS is unable to monitor the 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 ninety (90) calendar days or less;

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

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

SUBCHAPTER 5. MEMBER SERVICES

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-155 Extensive residential supports (ERS) [NEW]

(a) **Introduction.** ERS are provided by an agency, approved by Developmental Disabilities Services (DDS), that has a valid Oklahoma Health Care Authority contract for the service.

(1) ERS provide up to twenty-four (24) hours per day of direct support services, including the provision of more than one staff when the needs of the member indicate additional supports are required.

(2) ERS provides a level of supervision necessary to keep the member safe in the home and in the community and to assist the member with obtaining desired outcomes identified in the member's Individual Plan (Plan).

(b) **Provider approval criteria**. Prospective providers of ERS must demonstrate a history of effective services and supports to persons with challenging behaviors per OAC 340:100-5-57(c), emotional challenges or community protection needs. Provider approval requires review of historical information, when available, from DDS Quality Assurance Unit and Residential Unit. The DDS director or designee must approve the location of the home prior to the implementation of services. Each prospective provider submits written documentation of:

(1) a history of services to persons who present challenging behaviors, emotional challenges, or community protection needs, including:

(A) past experience;

(B) number of persons served;

(C) provider's perspective on the greatest challenges in serving persons eligible for ERS services; and

(D) provider's philosophy for service provision;

(2) financial viability through fiscal information when requested, including the anticipated budget related to the rate for ERS services;

(3) service provision plans, including:

(A) anticipated number of homes;

(B) location;

(C) gender to be served;

(D) population to be served; and

(E) availability of psychological, psychiatric, vocational and educational services in the proposed location;

(4) plans for staffing and program coordination; and

(5) staff qualifications, including any additional training provided.

(c) **Services provided.** Services and supports are based on person-centered principles and practices and consistent with OAC 317:40-1-3.

(1) The service includes but is not limited to:

(A) program supervision and oversight, which includes:

(i) 24-hour availability of response staff to:

(I) meet schedules or unpredictable needs in a way that promotes maximum dignity and independence; and

(II) provide supervision, safety and security consistent with the program described in the member's Plan; and

(ii) staff who are available to respond to a crisis to:

(I) help ensure safety; and

(II) assist the member to self-regulate to help prevent placement disruption;

(B) behavioral support, which includes supporting the member in being a valued member of the community. Challenging interactions may include but are not limited to:

(i) physical or verbal aggression;

(ii) sexually unsafe behaviors or actions;

(iii) victimizing other people or animals;

(iv) property destruction;

(v) self-harm;

(vi) suicidal ideations or attempts; and

(vii) stealing or other illegal behavior;

(C) activities of daily living, which includes instruction, hands-on support, supervision, modeling or prompting to:

(i) eat;

(ii) bathe;

(iii) dress;

(iv) toilet;

(v) complete personal hygiene;

(vi) transfer;

(vii) complete housework;

(viii) manage money;

(ix) engage in community safety;

(x) participate in recreation;
(xi) engage in socialization;
(xii) manage health;
(xiii) manage medication; or
(xiv) attend school and other community-based educational opportunities;
(D) coordinating overall safety and supports in the home;
(E) self-advocacy training and support, which includes, but is not limited to:
(i) training and assistance in supported decision making;
(ii) accessing needed services;
(iii) asking for help;
(iv) recognizing and reporting abuse, neglect, mistreatment, or exploitation of self,
(v) responsibility for one's own actions; and
(vi) participation in all meetings;
(F) development of communication skills;
(G) assistance with:
(i) emergency planning;
(ii) safety planning;
(iii) fire, weather and disaster drills; and
(iv) crisis intervention;
(H) community access support to enhance the abilities and skills necessary for the member to access typical activities and functions of community life.
(i) Accessing the community includes providing a wide variety of opportunities which may include:
(I) development of social, communication and other skills needed to successfully participate in the desired communities;
(II) facilitating and building natural relationships in the desired communities;
(III) participating in community education experiences or training;
(IV) participating in volunteer activities the member finds interesting and desirable;
(V) exploring and understanding available public transportation options; and
(VI) participating in pre-employment and employment activities;
(ii) Services are conducted in a variety of settings in which members interact with individuals without disabilities. Services may include:
(I) social skill development;
(II) adaptive skill development; and
(III) personnel to accompany and support the member in community settings; and
(I) implementation of recommended and approved follow-up counseling, behavioral, or other therapeutic interventions;
(J) implementation of services delivered under the direction of a licensed or certified professional in that discipline including, but not limited to:
(i) family training;
(ii) psychological services;
(iii) counseling services;
(iv) physical therapy;
(v) occupational therapy; and

(vi) speech therapy;

(K) medical and health care services that are integral to meeting the daily needs of the member, which include, but are not limited to:

(i) routine administration of medications; and

(ii) tending to the medical needs of members;

(L) the provision of staff training per Oklahoma Administrative Code (OAC) 340:100-3-38.14, to meet the specific needs of the member; and

(M) assisting the member in obtaining services and supplies.

(d) **Eligibility.** ERS are provided to members who:

(1) have challenging behaviors, emotional challenges, or community protection needs and require additional supports to enable them to reside successfully in community settings. These services are designed to assist members to acquire, retain and improve the self-help, socialization, and adaptive skills necessary to remain in the community;

(2) have needs that cannot be met in other traditional community settings;

(3) participate in the DDS Community Waiver, per OAC 317:40-1-1;

(4) need community residential services outside the family home;

(5) do not receive:

(A) home-and community-based services options per OAC 340:100-5-22.1;

(B) group home services per OAC 317:40-5-152;

(C) habilitation training specialist per OAC 317:40-5-110;

(D) respite care per OAC 317:30-5-517;

(E) homemaker per OAC 317:30-5-535; and

(F) intensive personal supports per OAC 317:40-5-151; and

(6) are eighteen (18) years of age or older, unless approved by the DDS director or designee.

(e) **Service requirements.** ERS must be:

(1) included in the member's Plan per OAC 340:100-5-51, including a description of the type(s) and intensity of supervision and assistance that must be provided to the member;

(2) authorized in the member's Plan of Care (POC);

(3) provided by the contracted provider agency chosen by the member or guardian;

(4) delivered per OAC 340:100-5-22.1; and

(5) provided directly to the member.

(f) **Home Requirements.** ERS are provided to eligible members living outside the family's home in a home:

(1) licensed by Oklahoma Human Services (OKDHS) Child Care Services when the member is a child in custody of OKDHS, Child Welfare Services; or

(2) leased or owned by the member receiving services.

(g) **Responsibilities of provider agencies.** Each agency providing ERS ensures:

(1) ongoing supports are available as needed when the member is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;

(2) compliance with all applicable DDS policy found at OAC 340:100; and

(3) that trained staff are available to the member as described in the Plan.

(4) a trainer of a nationally recognized person-centered planning program approved by DDS is employed as a member of the provider's leadership team or is contracted with the provider.

(5) A background investigation is conducted on staff per OAC 340:100-3-39.

(6) staff identified to work with children complete a Federal Bureau of Investigation (FBI) national criminal history search, which is based on the staff's fingerprints.

(h) **ERS claims.** No more than one unit of ERS per day may be billed.

(1) The provider agency claims one unit of service for each day during which the member receives ERS. A day is defined as the period between 12:00 a.m. and 11:59 p.m.

(2) Claims must not be based on budgeted amounts.

(3) When a member changes provider agencies, only the outgoing service provider agency claims for the day that the member moves.

(i) **Therapeutic leave.** ERS provides for therapeutic leave payments to enable the provider agency to retain direct support staff.

(1) Therapeutic leave is claimed when the member does not receive ERS services for 24-consecutive hours from 12:00 a.m. to 11:59 p.m. because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. ERS staff may be present with the member in the hospital as approved by the member's Personal Support Team (Team) in the Plan but are not responsible for the care of the patient.

(2) Therapeutic Leave must be authorized and documented in the POC.

(3) A member may receive therapeutic leave for no more than fourteen (14) consecutive days per event, not to exceed sixty (60) calendar days per POC year.

(4) The payment for a day of therapeutic leave is the same amount as the per diem rate for ERS.

(5) To promote continuity of staffing in the member's absence, the provider agency pays the staff member the salary that he or she would have earned if the member was not on therapeutic leave or provides the staff member a temporary, alternative work opportunity.

(j) **Transition.** Teams plan for a service recipient's transition to appropriate services when it is determined ERS is no longer necessary.

(1) Within six months of the service recipient's admission to ERS, the Team develops measurable, reasonable criteria for the service recipient's transition to a less restrictive environment that are:

(A) based on findings of the risk assessment completed by the Team per OAC 340:100-5-56.

(B) included in a written plan submitted to designated DDS State Office staff; and

(C) reviewed at least annually by the Team.

(2) All transitions from ERS must be approved by designated DDS State Office staff. DDS State Office staff may adjust the transition date when necessary.

(k) **DDS-initiated transition.** The DDS director or designee may initiate the transition process for a member receiving ERS who can be effectively served in another residential environment.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 115. PHARMACISTS

317:30-5-1225. Eligible Providers

Eligible Providers shall:

(1) Have and maintain a current license by the Oklahoma State Board of Pharmacy as described in Section 353.9 of Title 59 of Oklahoma Statutes and Title 535 of the Oklahoma Administrative Code, Chapter 10, Subchapter 7.

(2) Have a current contract with the Oklahoma Health Care Authority (OHCA)

317:30-5-1226. Covered Services

(a) OHCA covers medical services (as described in OAC 317:30-5, Part 1, Physicians) provided by a pharmacist when rendered within the licensure and scope of practice of the pharmacist as defined by state law and regulations found at 59 O.S. § 353.1, 59 O.S. § 353.30, OAC 535:10-9-1 through OAC 535:10-9-15, and OAC 535:10-11-1 through OAC 535:10-11-6.

(b) Medical services rendered by pharmacists are subject to the same limitations described in OAC 317:30-5, Part 1, Physicians.

317:30-5-1227. Reimbursement

(a) Payment for covered services (as described in OAC 317:30-5-1226) to eligible providers (as described in 30-5-1225) shall be made when the same service would have been covered if ordered or performed by a physician.

(b) Payment is made per the methodology established in the Oklahoma Medicaid State Plan.

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1091. Definition of I/T/U services

(a) As described in 42 CFR 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing, preventive care (including immunizations).

(b) Further, 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.

(c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence. Provider contracts must meet the provider participation requirements found at OAC 317:30-5-1096.

(d) I/T/U outpatient encounters include but are not limited to:

(1) Physicians' services and supplies incidental to a physician's services;

(2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];

(3) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse

midwives (CNMs), or specialized advanced practice nurse practitioners;
(4) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);
(5) Public health nursing services, within the scope of their licensure, include but are not limited to services in the following areas:

(A) Phlebotomy;
(B) Wound care;
(C) Public health education;
(D) Administration of immunizations;
(E) Administration of medication;
(F) Child health screenings meeting EPSDT criteria;
(G) Smoking and Tobacco Use Cessation Counseling;
(H) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and
(I) General health assessments and management of conditions such as tuberculosis, diabetes and hypertension.

(6) Visiting nurse services to the homebound;
(7) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and
(8) Dental services.
(9) Pharmacists' services found in OAC 317:30-5-1226