Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
January 9th, 2025
1:00 – 3:00 PM
Charles Ed McFall Board Room

# AGENDA

**Please access via zoom:**
**https://www.zoomgov.com/webinar/register/WN_DgUH4IG1QYGgyVxPxnxNTg**
**Telephone: 1-669-254-5252 Webinar ID: 160 297 4109**

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

II. Action Item: Approval of Minutes of the November 7th, 2024: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Reports: **Josh Richards, Senior Director of Financial Services**

VI. Legislative Updates: **Christina Foss, Chief of Staff**

VII. Change of Service Provision Updates: **Sandra Puebla, Deputy State Medicaid Director**

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

**A.** Transition in Value based payment: **Folake Adedeji, Chief Quality Officer**

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

**A. APA WF # 24-11 Doula Certifying Organization Criteria**
**B. APA WF # 24-13 Program of All-Inclusive Care for the Elderly (PACE) Policy**
**C. APA WF # 24-17A&B Electronic Visit Verification (EVV) Revisions**
**D. APA WF # 24-28 Crisis Intervention Services Limitations**
**E. APA WF # 24-29 Diagnosis Clarification for Inpatient Psychiatric Services**
**F. APA WF # 24-30 Updates to Residential Substance Use Disorder (SUD) Policy**
**G. APA WF 24-31 A&B Removal of Outdated Language**
**H. APA WF # 24-32 Removing Certain Drugs from 340b Program**
**I. APA WF # 24-33 In Lieu of Service or Setting (ILOS)**

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

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

March 6, 2025
May 1, 2025
July 10, 2025
September 11, 2025
November 6, 2025

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the November 7th, 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 1:02 PM.

***Delegates present were:*** Mr. Nick Barton, Ms. Janet Cizek, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Jennifer King, Dr. J. Daniel Post, and Dr. Jason Rhynes

**Alternates present were**: Ms. Heather Pike, and Mr. Paul Wright providing a quorum.

***Delegates absent without an alternate were*:** Mr. Brett Coble, Ms. Tina Johnson, Ms. Melissa Miller, Dr. Raymond Smith, Dr. Marny Dunlap and Dr. Whitney Yeates.

## II. Approval of the September 12th, 2024 Minutes

Medical Advisory Committee

**The motion to approve the minutes was by Ms. Wanda Felty by Dr. J. Daniel Post and passed unanimously.**

## III. Public Comments (2-minute limit):

There were no public comments.

## IV. MAC Member Comments/Discussion:

Dr. Rhynes mentioned that in April he requested a year-to-year comparison regarding access for children. The children and comprehensive exams from April show a significant decrease in the number of kids being seen.

Ms. Wanda Felty stated that families in the ABD population are wondering why their child with a disability, doesn't have the option to access the same services as children in SoonerSelect or other covered entities, and welcomes the opportunity to have more conversation with OHCA.

## V. IMD Post Award Forum:

Melissa Miller, Senior Director, Behavioral Health Policy and Planning

Ms. Tanesha Hooks presented on behalf of Melissa Miller. Ms. Hooks gave an overview of Oklahoma's IMD waiver, which was approved in December of 2020. The waiver is effective for five years from the approval date. Oklahoma's IMD waiver application includes both categories of services through joint Serious Mental Illness (SMI) and Substance Use Disorder (SUD) waiver. Included populations and services include inpatient stays in psychiatric hospitals for ages 21-64, crisis stabilization services in crisis units for ages 18-64, and substance use disorder treatment in

residential settings for ages 18-64 and individuals under 18. As of January 2022, a requirement for residential substance use disorder providers to obtain national accreditation was implemented. Effective July 2022 increases to behavioral health reimbursement rates include all levels of residential substance use disorder treatment. The state achieved statewide certification of Certified Community Behavioral Health Clinics (CCBHCs) at the end of 2021. ODMHSAS has expanded and is continuing to expand a statewide crisis continuum of care including, urgent recovery clinics, crisis units, mobile crisis teams, and the 988-call center.

**VI. SoonerSelect Choice Post Award Forum:**

Heather Cox, Policy and Program Management

Ms. Cox stated that the OHCA administers SoonerCare Choice, under a section 1115 Waiver which was originally approved in 1996 and renewed multiple times since. It utilizes a primary care case management model in which we contract with primary care providers as patient centered medical homes. The aim of SoonerCare Choice is to deliver high quality, accessible, and cost-effective care through Health Access Networks, also called the HANs and Health Management Programs, HMP. They employ care managers for members of complex health needs, address medical, social, and behavioral challenges. They support members with chronic illnesses to prevent adverse outcomes and manage costs. In 2004 OHCA launched another program called Insure Oklahoma. Under this same demonstration the employer sponsored insurance program offers subsidized insurance for small business employees, their spouses and other low-income adults that are not eligible for Medicaid. For more detailed information, see agenda item 6 in the MAC agenda.

**VII. OHCA Updates:**

Christina Foss, Chief of Staff

Ms. Foss gave an update on our budget request which was due October 1. Our budget has been increasing consistently over the past several years and due to several reasons. A comparison from 20218, our budget was 5.7 million and our request for SFY26 is 11.2 million. A few factors being expansion, State and Federal mandates that continue to increase, along with supplements, which have also increased through the years. We are also requesting an additional 126 million in state appropriations. This request is to maintain current operations. The 126 million also includes 30 million that we absorbed as last year's budget for Long Term Care facility rate increases. Last session, part of our budget included an additional increase in Long Term Care rates to the tune of 30 million, so Legislature asked us to absorb that as part of our current budget. We also saw a decrease in FMAP, which is our federal share we receive.

**VIII. SoonerSelect Medical Request to change Service Provisions:**

Paula Root, Chief Medical Officer

Dr. Root discussed Oklahoma Complete Health and Oklahoma Complete Health Children's Specialty Program submitting a formal request to OHCA for review and approval to change service provisions. OHCA Subject matter experts (SMEs) reviewed the request, evaluating it in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the request. Oklahoma Complete Health has used InterQual (A change HealthCare Product) as criteria to determine the appropriateness of requests for Magnetic Resonance Imaging (MRI) of Lumar Spine or Spinal Canal. InterQual requires either physical therapy or home exercises or activity modification for more than 4 weeks within the past year. Oklahoma Complete Health proposes to change the PA tool from InterQual to Evolent Health (previously known as National Imaging Association, Inc.) Evolent requires at least 6 weeks of conservative's therapy in the most recent 6 months. OHCAs decision was to approve. For more detailed information see agenda item 8 in the MAC agenda.

**IX. SoonerSelect Dental Requests to change Service Provisions for DentaQuest:**

Bernard Rhone, Director of Dental Services

Dr. Rhone discussed DentaQuest submitting a formal request 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 will continue with their historical and current practice of allowing separate payment for D3320/D3221 when filed on the same tooth by the same provider and/or location on a different date of service than the D3310/D3320/D3330. OHCA has approved for dates of service on or after December 9, 2024. For more detailed information see agenda item 9 in the MAC agenda.

**X. Proposed Rule Changes: Presentation, Discussion, and vote:**

Kasie McCarty, Senior Director of Federal and State Authorities

**APA WF # 24-14 Hospice Benefit Expansion —** The Oklahoma Health Care Authority (OHCA) proposes emergency revisions that are necessary to comply with newly amended state law. Currently, hospice coverage is limited to children, expansion adults, and the dual eligible population. In accordance with House bill (HB) 3980 of the 2024 legislative session, the proposed revisions will expand hospice coverage to include all full-benefit Medicaid members. Existing criteria and payment methodologies will be applied to any new populations.

**Budget Impact:** The estimated budget impact for SFY25 will be an increase in the total amount of $20,277.00; with $6,675.19 in state share. The estimated total cost for SFY26 is an increase of $40,554.00; with $13,350.38 in state share.

**The rule change motion to approve was by Dr. J. Daniel Post and seconded by Dr. Paul Wright and passes unanimously**.

**APA WF # 24-18 Third Party Liability (TPL) for School-based Services —** The Oklahoma Health Care Authority (OHCA) proposes to permit an exception to current TPL rules so that Medicaid is the payor of first resort, or prior to federal IDEA funds, for Medicaid-covered services documented within a student's an Individualized Education Program (IEP) and (IFSP) in accordance with section 1903(c) of the Social Security Act. The Agency will then "pay and chase" to recoup the funds from the liable third party. Further, schools can still bill third party payors; however, it will not be required. This change aims to remove barriers for Local Education Agencies (LEA) to access Medicaid payment to support critical services for children with disabilities.

**Budget Impact:** The estimated total cost for SFY25 is $35,253; with $11,605 in state share. The estimated total cost for SFY26 is $70,507; with $23,533 in state share.

**The rule change motion to approve was by Dr. Arlen Foulks and seconded by Ms. Wanda Felty and passes unanimously**.

**APA WF # 24-19 Updating Abortion Policy —** The proposed revisions align OHCA policy with state law on abortion. Currently, policy includes that abortion services can be accessed in instances of rape, incest, and/or when the mother's life is in danger; however, the exceptions of rape and incest will be removed.

**Budget Impact:** Budget neutral.

**The rule change motion to approve was by Dr. Paul Wright and seconded by Dr. Arlen Foulks with 5 abstaining, and 4 yes. The recommendation has not moved forward.**

**APA WF # 24-24 Medication Assisted Treatment (MAT) Clarification —** The proposed emergency rule revisions are a request from ODMHSAS to comply with recent federal rule changes at 42 CFR § 8.12. This rule change ensures that refusal of members to participate in treatment phases of therapy, rehabilitation, case management, and peer recovery support services as described in OAC 317:30-5-241.7(f) will not prohibit them from receiving medications from an Opioid Treatment Program.

**Budget Impact:** Budget neutral.

**The rule change motion to approve as by Ms. Wanda Felty and seconded by Dr. Paul Wright and passes unanimously**.

**APA WF # 24-25 Psychological Testing Limit Increase —** The proposed emergency rule revisions are a request from ODMHSAS to increase the initial limit on psychological testing hours from eight (8) to ten (10). This change will allow for an adequate initial baseline of testing hours for most testing instruments and ensure that members who require psychological testing have sufficient initial coverage. Providers may still request an additional six (6) hours for complex testing, bringing the total to sixteen (16) hours.

**Budget Impact:** The estimated budget impact for SFY25 will be an increase in the total amount of $113,838; with $24,463 in state share. The estimated total cost for SFY26 is an increase $227,676; with $48,927 in state share. The state share will be covered by ODMHSAS.

**The rule change motion to approve as by Dr. Paul Wright and seconded by Mr. Nick Barton and passes unanimously**.

**APA WF #24-21 Certified Registered Nurse Anesthetists (CRNA) Equalization —** The OHCA proposes emergency rule revisions to increase access to care and help alleviate workforce shortages by increasing rates for CRNAs practicing within scope of practice, in collaboration with a physician or dentist licensed in this state. Reimbursement will be increased to 100% of the physician fee schedule, from the existing 80%. In situations when the CRNA is practicing under medical direction, reimbursement will remain consistent with established methodology within the Title XIX State Plan, which is 50% of the physician fee schedule.

**Budget Impact:** The estimated budget impact for SFY25 will be an increase in the total amount of $6,642,110; with $2,183,594 in state share. The estimated total cost for SFY26 is an increase of $7,970,533; with $2,750,817 in state share.

**The rule change motion to approve as by Dr. J. Daniel Post and seconded by Ms. Janet Cizek and passes unanimously**.

The Agency is requesting the effective date to be January 1, 2025, or upon receiving gubernatorial approval.

**APA WF # 24-13 Program of All-Inclusive Care for the Elderly (PACE) Licensure Policy —** The proposed rule changes remove the requirement that PACE providers be licensed as an adult day care and clarify some OHCA regulatory requirements of PACE providers. HB3238 of the 2024 legislative session, found in statute at 56 OS 1017.7, 63 OS 1-872, and 63 OS 1-1961, amends the Adult Day Care Act and the Home Care Act to exempt PACE organizations from the licensure requirements of adult day cares and home health organizations. It also assigns new regulatory authority to the OHCA to enforce federal PACE regulations (42 CFR Part 460), including but not limited to evaluation, monitoring, and oversight requirements. These rule changes will reduce the administrative burden on PACE providers and ensure OHCA expectations and requirements are clear.

**Budget Impact:** Budget neutral

**The rule change motion to approve as by Dr. Arlen Foulks and seconded by Dr. J. Daniel Post and passes unanimously**.

**APA WF # 24-34 Community Health Services —** The proposed emergency rule changes are a request of Oklahoma State Department of Health (OSDH) to add coverage and reimbursement for Community Health Services provided within a public health clinic. These services are provided by a Community Health Worker (CHW) and must be ordered by a physician. Services include screening and assessments, health education/coaching, and health system navigation. Eligible providers must obtain a certificate of completion of a C3 core competency-based training offered by OSDH or an affiliated local health department and work and bill under a licensed provider. Eligible members must have a diagnosis of a chronic condition, unmet health-related social need, received a screening, or be pregnant to receive services.

**Budget Impact:** The estimated budget impact for SFY25 will be an increase in the total amount of $130,704; with $43,028 in state share. The estimated total cost for SFY26 is $871,360; with $285,980 in state share. The state share will be covered by OSDH.

**The rule change motion to approve as by Dr. J. Daniel Post and seconded by Dr. Arlen Foulks and passes unanimously**.

XI. **New Business:**

Chairman, Jason Rhynes, O.D.

There was no new business addressed.

**XII. Adjourn:**

Chairman, Jason Rhynes, O.D.

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Arlen Foulks and seconded by Dr. J. Daniel Post, there was no dissent and the meeting adjourned at 2:36pm.

OKLAHOMA
Health Care Authority

# FINANCIAL REPORT

For the Four Month Period Ending October 31, 2024
Submitted to the CEO & Board

- Revenues for OHCA through October, accounting for receivables, were **$2,972,257,603** or **2.1% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,992,290,825** or **3.3% under** budget.
- The state dollar budget variance through October is a positive **$36,732,529.**
- The budget variance is primarily attributable to the following (in millions):

| | | |
|---|---|---|
| **Expenditures:** | | |
| Administration | | (1.6) |
| Medicaid Program Variance | | 103.1 |
| **Revenues:** | | |
| Federal Funds | | (78.8) |
| Drug Rebate | | 10.7 |
| Medical Refunds | | 6 |
| Taxes and Fees | | (2.7) |
| **Total FY 24 Variance** | **$** | **36.7** |

**ATTACHMENTS**

# OKLAHOMA HEALTH CARE AUTHORITY
## Summary of Revenues & Expenditures: OHCA
## SFY 2025, For the Four Months Period Ending October 31, 2024

| REVENUES | FY 25 Budget YTD | FY 25 Actual YTD | Variance | % Over/ (Under) |
|---|---|---|---|---|
| State Appropriations | $ 442,683,474 | $ 442,683,474 | $ - | 0.0% |
| Federal Funds | 2,092,175,401 | 2,013,371,437 | (78,803,964) | (3.8)% |
| Tobacco Tax Collections | 13,018,633 | 12,915,184 | (103,450) | (0.8)% |
| Quality of Care Collections | 35,486,555 | 33,139,720 | (2,346,835) | (6.6)% |
| Prior Year Carryover | 47,493,337 | 47,493,337 | - | 0.0% |
| Federal Deferral - Interest | 207,323 | 207,323 | - | 0.0% |
| Drug Rebates | 202,621,288 | 213,305,408 | 10,684,120 | 5.3% |
| Medical Refunds | 17,418,841 | 23,454,828 | 6,035,986 | 34.7% |
| Prior Year Carryover Supplemental Hospital Offset Payment Program | - | - | - | 0.0% |
| Supplemental Hospital Offset Payment Program | 184,537,057 | 183,756,659 | (780,398) | (0.4)% |
| Other Revenues | 1,439,613 | 1,930,234 | 490,621 | 34.1% |
| **TOTAL REVENUES** | **$ 3,037,081,522** | **$ 2,972,257,603** | **$ (64,823,919)** | **(2.1)%** |

| EXPENDITURES | FY 25 Budget YTD | FY 25 Actual YTD | Variance | % (Over)/ Under |
|---|---|---|---|---|
| **ADMINISTRATION - OPERATING** | **$ 21,635,238** | **$ 22,100,773** | **$ (465,534)** | **(2.2)%** |
| **ADMINISTRATION - CONTRACTS** | **$ 58,927,766** | **$ 60,025,798** | **$ (1,098,032)** | **(1.9)%** |
| | | | | |
| **MEDICAID PROGRAMS** | | | | |
| Managed Care: | | | | |
| SoonerCare Choice | 12,530,288 | 12,987,679 | (457,391) | (3.7)% |
| SoonerSelect Medical | 662,390,237 | 588,344,675 | 74,045,562 | 11.2% |
| SoonerSelect Dental | 49,274,289 | 46,365,353 | 2,908,936 | 5.9% |
| SoonerSelect DPP - Provider Incentives | 8,408,764 | 12,900,891 | (4,492,126) | (53.4)% |
| SoonerSelect CSP | 42,310,568 | 51,443,369 | (9,132,801) | (21.6)% |
| | | | | |
| Acute Fee for Service Payments: | | | | |
| Hospital Services | 403,488,725 | 377,895,210 | 25,593,515 | 6.3% |
| Behavioral Health | 8,733,288 | 5,837,555 | 2,895,733 | 33.2% |
| Physicians | 117,139,888 | 95,888,762 | 21,251,127 | 18.1% |
| Dentists | 20,265,369 | 22,349,057 | (2,083,688) | (10.3)% |
| Other Practitioners | 11,308,332 | 12,932,918 | (1,624,586) | (14.4)% |
| Home Health Care | 11,125,810 | 11,730,529 | (604,719) | (5.4)% |
| Lab & Radiology | 9,724,616 | 6,737,259 | 2,987,357 | 30.7% |
| Medical Supplies | 28,325,652 | 27,651,679 | 673,973 | 2.4% |
| Ambulatory/Clinics | 142,845,040 | 150,311,168 | (7,466,128) | (5.2)% |
| Prescription Drugs | 308,296,600 | 313,303,717 | (5,007,117) | (1.6)% |
| OHCA Therapeutic Foster Care | 160,026 | (12,123) | 172,149 | 107.6% |
| | | | | |
| Other Payments: | | | | |
| Nursing Facilities | 317,624,524 | 315,350,557 | 2,273,967 | 0.7% |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities Private | 32,882,581 | 30,355,073 | 2,527,508 | 7.7% |
| Medicare Buy-In | 61,466,193 | 61,471,323 | (5,131) | (0.0)% |
| Transportation | 38,861,236 | 35,783,988 | 3,077,248 | 7.9% |
| Money Follows the Person-OHCA | 540,757 | 584,580 | (43,823) | (8.1)% |
| Electronic Health Records-Incentive Payments | (391) | (391) | - | 0.0% |
| Part D Phase-In Contribution | 42,719,614 | 42,299,353 | 420,261 | 1.0% |
| Supplemental Hospital Offset Payment Program | 678,586,207 | 683,685,038 | (5,098,831) | (0.8)% |
| Telligen | 4,186,675 | 3,967,037 | 219,638 | 5.2% |
| | | | | |
| **Total OHCA Medical Programs** | **3,013,194,887** | **2,910,164,254** | **103,030,633** | **3.4%** |
| | | | | |
| OHCA Non-Title XIX Medical Payments | 89,382 | - | 89,382 | 100.0% |
| | | | | |
| **TOTAL OHCA** | **$ 3,093,847,273** | **$ 2,992,290,825** | **$ 101,556,448** | **3.3%** |
| | | | | |
| **REVENUES OVER/(UNDER) EXPENDITURES** | **$ (56,765,751)** | **$ (20,033,222)** | **$ 36,732,529** | |

# OKLAHOMA HEALTH CARE AUTHORITY

## Total Medicaid Program Expenditures
## by Source of State Funds
## SFY 2025, For the Four Months Period Ending October 31, 2024

| Category of Service | Total | Health Care Authority | Quality of Care | Insure Oklahoma | SHOPP | BCC | Other State Agencies |
|---|---|---|---|---|---|---|---|
| SoonerCare Choice | 12,987,679 | 12,987,361 | $ - | $ - | $ - | $ 318 | $ - |
| SoonerSelect Medical | 698,995,765 | 588,344,675 | $ - | $ - | $ - | $ - | $ 110,651,090.24 |
| SoonerSelect Dental | 46,365,353 | 46,365,353 | | | | | |
| SoonerSelect DPP - Provider Incentives | 12,900,891 | 12,900,891 | $ - | $ - | $ - | $ - | $ - |
| SoonerSelect CSP | 51,443,369 | 51,443,369 | $ - | $ - | $ - | $ - | $ - |
| Inpatient Acute Care | 455,005,440 | 228,777,314 | 162,229 | (74) | 112,780,294 | 24,371 | 113,261,306 |
| Outpatient Acute Care | 191,614,172 | 148,693,895 | 13,868 | (124) | 42,682,999 | 223,533 | - |
| Behavioral Health - Inpatient | 25,483,573 | 3,745,838 | - | - | 4,724,728 | - | 17,013,007 |
| Behavioral Health - Psychiatrist | 4,134,633 | 2,091,717 | - | - | 2,042,916 | - | - |
| Behavioral Health - Outpatient | 5,280,441 | - | - | - | - | - | 5,280,441 |
| Behavioral Health-Health Home | - | - | - | - | - | - | - |
| Behavioral Health Facility- Rehab | 57,515,049 | - | - | - | - | 847 | 57,515,049 |
| Behavioral Health - Case Management | 912,154 | - | - | - | - | - | 912,154 |
| Behavioral Health - PRTF | 3,082,393 | - | - | - | - | - | 3,082,393 |
| Behavioral Health - CCBHC | 64,572,372 | - | | | | | 64,572,372 |
| Residential Behavioral Management | 764,894 | - | - | - | - | - | 764,894 |
| Targeted Case Management | 15,615,381 | - | - | - | - | - | 15,615,381 |
| Therapeutic Foster Care | (12,123) | (12,123) | - | - | - | - | - |
| Physicians | 135,926,349 | 95,722,554 | 19,367 | (96) | - | 146,841 | 40,037,684 |
| Dentists | 22,349,057 | 22,345,356 | - | - | - | 3,701 | - |
| Mid Level Practitioners | 57,481 | 57,481 | - | - | - | - | - |
| Other Practitioners | 12,875,437 | 12,724,041 | 148,788 | - | - | 2,608 | - |
| Home Health Care | 11,730,529 | 11,730,210 | - | - | - | 319 | - |
| Lab & Radiology | 6,737,259 | 6,734,992 | - | - | - | 2,267 | - |
| Medical Supplies | 27,651,679 | 26,746,092 | 903,844 | - | - | 1,743 | - |
| Clinic Services | 154,845,839 | 147,816,240 | - | - | - | 19,180 | 7,010,419 |
| Ambulatory Surgery Centers | 2,475,748 | 2,475,748 | - | - | - | - | - |
| Personal Care Services | 3,629,866 | - | - | - | - | - | 3,629,866 |
| Nursing Facilities | 315,350,557 | 217,060,039 | 98,290,519 | - | - | - | - |
| Transportation | 35,701,896 | 34,715,543 | 924,705 | - | - | 61,647 | - |
| IME/DME | 42,776,627 | - | - | - | - | - | 42,776,627 |
| ICF/IID Private | 30,355,073 | 25,641,337 | 4,713,735 | - | - | - | - |
| ICF/IID Public | 5,402,388 | - | - | - | - | - | 5,402,388 |
| CMS Payments | 103,770,676 | 103,599,942 | 170,734 | - | - | - | - |
| Prescription Drugs | 313,303,446 | 313,156,748 | - | (271) | - | 146,969 | - |
| Miscellaneous Medical Payments | 82,092 | 82,092 | - | - | - | - | - |
| Home and Community Based Waiver | 111,607,678 | - | - | - | - | - | 111,607,678 |
| Homeward Bound Waiver | 28,023,961 | - | - | - | - | - | 28,023,961 |
| Money Follows the Person | 2,049,450 | 584,580 | - | - | - | - | 1,464,870 |
| In-Home Support Waiver | 28,079,451 | - | - | - | - | - | 28,079,451 |
| ADvantage Waiver | 105,363,644 | - | - | - | - | - | 105,363,644 |
| Family Planning/Family Planning Waiver | 321,010 | - | - | - | - | - | 321,010 |
| Premium Assistance* | 8,798,054 | - | - | 8,798,054 | - | - | - |
| Directed Payments | 521,454,101 | - | - | - | 521,454,101 | - | - |
| Telligen | 3,967,037 | 3,967,037 | - | - | - | - | - |
| Electronic Health Records Incentive Payments | (391) | (391) | - | - | - | - | - |
| **Total Medicaid Expenditures** | **$ 3,681,347,427** | **$ 2,120,497,929** | **$ 105,347,790** | **$ 8,797,488** | **$ 683,685,038** | **$ 634,344** | **$ 762,385,685** |

* Includes $8,744,399.70 paid out of Fund 245

# OKLAHOMA HEALTH CARE AUTHORITY

## Summary of Revenues & Expenditures:
## Other State Agencies
## SFY 2025, For the Four Months Period Ending October 31, 2024

| REVENUE | | FY 25 Actual YTD |
|---|---|---|
| Revenues from Other State Agencies | | 217,857,429 |
| Federal Funds | | 543,364,516 |
| **TOTAL REVENUES** | **$** | **761,221,946** |

| EXPENDITURES | | Actual YTD |
|---|---|---|
| **Oklahoma Human Services** | | |
| Home and Community Based Waiver | $ | **111,607,678** |
| Money Follows the Person | | **1,464,870** |
| Homeward Bound Waiver | | **28,023,961** |
| In-Home Support Waivers | | **28,079,451** |
| Advantage Waiver | | **105,363,644** |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities Public | | **5,402,388** |
| Personal Care | | **3,629,866** |
| Residential Behavioral Management | | **316,899** |
| Targeted Case Management | | **13,854,462** |
| **Total Oklahoma Human Services** | | **297,743,218** |
| **State Employees Physician Payment** | | |
| Physician Payments | | **40,037,684** |
| **Total State Employees Physician Payment** | | **40,037,684** |
| **Education Payments** | | |
| Indirect Medical Education | | **41,427,113** |
| Direct Medical Education | | **1,349,514** |
| DSH | | **-** |
| **Total Education Payments** | | **42,776,627** |
| **Office of Juvenile Affairs** | | |
| Targeted Case Management | | **129,658** |
| Residential Behavioral Management | | **447,996** |
| **Total Office of Juvenile Affairs** | | **577,653** |
| **Department of Mental Health & Substance Abuse Services** | | |
| Case Management | | **912,154** |
| Inpatient Psychiatric Free-standing | | **17,013,007** |
| Outpatient | | **5,280,441** |
| Health Homes | | **-** |
| Psychiatric Residential Treatment Facility | | **3,082,393** |
| Certified Community Behavioral Health Clinics | | **64,572,372** |
| Rehabilitation Centers | | **57,515,049** |
| SoonerSelect | | **110,651,090** |
| **Total Department of Mental Health & Substance Abuse Services** | | **259,026,506** |
| **State Department of Health** | | |
| Children's First | | **64,188** |
| Sooner Start | | **-** |
| Health Clinics | | **396,092** |
| Early Intervention | | **688,160** |
| Early and Periodic Screening, Diagnosis, and Treatment Clinic | | **98,481** |
| Family Planning | | **84,112** |
| Family Planning Waiver | | **235,600** |
| Maternity Clinic | | **14,103** |
| **Total Department of Health** | | **1,580,737** |
| **County Health Departments** | | |
| EPSDT Clinic | | **9,305** |
| Family Planning Waiver | | **1,298** |
| **Total County Health Departments** | | **10,603** |
| **State Department of Education** | | **264,882** |
| **Public Schools** | | **614,031** |
| **Medicare DRG Limit** | | **104,592,065** |
| **Native American Tribal Agreements** | | **6,492,438** |
| **Department of Corrections** | | **2,765,912** |
| **JD McCarty** | | **5,903,328** |
| **Total OSA Medicaid Programs** | **$** | **762,385,685** |
| **OSA Non-Medicaid Programs** | **$** | **38,982,468** |
| **Accounts Receivable from OSA** | **$** | **40,146,207** |

# OKLAHOMA HEALTH CARE AUTHORITY
## SUMMARY OF REVENUES & EXPENDITURES:
### Fund 205: Supplemental Hospital Offset Payment Program Fund
### SFY 2025, For the Four Months Period Ending October 31, 2024

| REVENUES | | FY 25 Revenue |
|---|---|---|
| SHOPP Assessment Fee | | 183,885,852 |
| Federal Draws | $ | 517,449,914 |
| Interest | | 166,566 |
| Penalties | | - |
| TOTAL REVENUES | $ | 701,502,332 |

| EXPENDITURES | Quarter | Quarter | Regular FMAP | CHIP | Expansion | Quarter | Quarter | | FY 25 Expenditures |
|---|---|---|---|---|---|---|---|---|---|
| Program Costs: | 7/1/23 - 9/30/23 | 10/1/23 - 12/31/23 | | | | 1/1/24 - 3/31/24 | 4/1/24 - 6/30/24 | | |
| Hospital - Inpatient Care | 37,674,703 | 37,674,703 | 37,674,703 | | 18,715,444 | - | - | $ | 75,349,406 |
| Hospital -Outpatient Care | 15,398,409 | 14,398,409 | 14,398,409 | | 6,206,554 | - | - | $ | 29,796,818 |
| Psychiatric Facilities-Inpatient | 1,566,648 | 1,566,648 | 1,566,648 | | 795,716 | - | - | $ | 3,133,296 |
| Rehabilitation Facilities-Inpatient | 677,400 | 677,400 | 677,400 | | 344,058 | - | - | $ | 1,354,800 |
| Directed Payments - Inpatient | 77,961,764 | 77,961,764 | 77,961,764 | 4,351,201 | 43,080,527 | | - | $ | 155,923,528 |
| Directed Payments - Outpatient | 70,653,413 | 70,653,413 | 70,653,413 | 12,588,198 | 49,542,532 | | - | $ | 141,306,826 |
| Directed Payments - Psych | 2,549,415 | 2,549,415 | 2,549,415 | | | | - | $ | 5,098,831 |
| Directed Payments - Inpatient - CHIP | 4,351,201 | 4,351,201 | | | | | - | $ | 8,702,402 |
| Directed Payments - Outpatient - CHIP | 12,588,198 | 12,588,198 | | | | | - | $ | 25,176,397 |
| Directed Payments - Psych - CHIP | - | - | | | | | - | $ | - |
| Hospital - Inpatient Care - Expansion | 18,715,444 | 18,715,444 | | | | - | - | $ | 37,430,887 |
| Hospital -Outpatient Care - Expansion | 6,679,627 | 6,206,554 | | | | - | - | $ | 12,886,182 |
| Psychiatric Facilities-Inpatient - Expansion | 795,716 | 795,716 | | | | - | - | $ | 1,591,432 |
| Rehabilitation Facilities-Inpatient - Expansion | 344,058 | 344,058 | | | | - | - | $ | 688,116 |
| Directed Payments - Inpatient - Expansion | 43,080,527 | 43,080,527 | | | | | - | $ | 86,161,054 |
| Directed Payments - Outpatient - Expansion | 49,542,532 | 49,542,532 | | | | - | - | $ | 99,085,063 |
| Directed Payments - Psych - Expansion | | | | | | | | $ | - |
| Total OHCA Program Costs | 342,579,055 | 341,105,983 | 205,481,752 | 16,939,400 | 118,684,831 | - | - | | 683,685,038 |
| Total Expenditures | | | | | | | | $ | 683,685,038 |

| | | |
|---|---|---|
| *SHOPP Revenue transferred to Fund 340 for Medicaid Program expense* | $ | 86,089,946 |

*** Expenditures and Federal Revenue processed through Fund 340

# OKLAHOMA HEALTH CARE AUTHORITY

## SUMMARY OF REVENUES & EXPENDITURES:

## Fund 230: Nursing Facility Quality of Care Fund

## SFY 2025, For the Four Months Period Ending October 31, 2024

| REVENUES | Total Revenue | State Share |
|---|---|---|
| | | $ - |
| Quality of Care Assessment | $ 33,114,831 | $ 33,114,831 |
| *Quality of Care Penalties (*Non-Spendable Revenue)* | $ 60,060 | $ 60,060 |
| Interest Earned | $ 24,889 | $ 24,889 |
| **TOTAL REVENUES** | **$ 33,199,780** | **$ 33,199,780** |

| EXPENDITURES | FY 25 Total $ YTD | FY 25 State $ YTD | Total State $ Cost |
|---|---|---|---|
| **Program Costs** | | | |
| Nursing Facility Rate Adjustment | $ 97,108,647 | $ 31,649,208 | |
| Eyeglasses and Dentures | 90,632 | $ 29,538 | |
| Personal Allowance Increase | 1,091,240 | $ 355,562 | |
| Coverage for Durable Medical Equipment and Supplies | 903,844 | $ 294,495 | |
| Coverage of Qualified Medicare Beneficiary | 344,252 | $ 112,166 | |
| Part D Phase-In | 170,734 | $ 170,734 | |
| ICF/IID Rate Adjustment | 1,629,397 | $ 530,951 | |
| Acute Services ICF/IID | 3,084,338 | $ 1,005,226 | |
| Non-emergency Transportation - Soonerride | 924,705 | $ 301,306 | |
| NF Covid-19 Supplemental Payment | - | $ - | |
| ICF Covid-19 Supplemental Payment | - | $ - | |
| Ventilator NF DME Supplemental Payment | | $ - | |
| **Total Program Costs** | **$ 105,347,790** | **$ 34,449,186** | **$ 34,449,186** |
| | | | |
| **Administration** | | | |
| OHCA Administration Costs | $ 104,135 | $ 52,067 | |
| OHS-Ombudsmen | - | - | |
| OSDH-Nursing Facility Inspectors | - | - | |
| Mike Fine, CPA | - | - | |
| **Total Administration Costs** | **$ 104,135** | **$ 52,067** | **$ 52,067** |
| | | | |
| **Total Quality of Care Fee Costs** | **$ 105,451,924** | **$ 34,501,254** | |
| | | | |
| **TOTAL STATE SHARE OF COSTS** | | | **$ 34,501,254** |

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

# OKLAHOMA HEALTH CARE AUTHORITY
## SUMMARY OF REVENUES & EXPENDITURES:
### Insure Oklahoma Program (Fund 245: HEEIA)
### SFY 2025, For the Four Months Period Ending October 31, 2024

| REVENUES | FY 24 Carryover | FY 25 Revenue | Total Revenue |
|---|---|---|---|
| *Prior Year Balance* | $ 1,411,645 | | |
| *State Appropriations* | - | | |
| *Federal Draws - Prior Year* | 113,167 | | |
| Total Prior Year Revenue | | | 1,524,812 |
| *Transfer to 340 for Expansion-current year* | | - | - |
| Tobacco Tax Collections | - | 10,622,277 | 10,622,277 |
| Interest Income | - | 29,258 | 29,258 |
| Federal Draws | - | 6,188,801 | 6,188,801 |
| **TOTAL REVENUES** | $ 1,524,812 | $ 16,840,336 | $ 18,365,148 |

| EXPENDITURES | | FY 24 Expenditures | FY 25 Expenditures | Total State $ YTD |
|---|---|---|---|---|
| **Program Costs:** | | | | |
| | Employer Sponsored Insurance | | $ 8,744,400 | $ 8,744,400 |
| | College Students/ESI Dental | | 53,654 | 17,496 |
| **Individual Plan** | | | | |
| | SoonerCare Choice | | $ - | $ - |
| | Inpatient Hospital | | (74) | (24) |
| | Outpatient Hospital | | (124) | (40) |
| | BH - Inpatient Services-DRG | | - | - |
| | BH -Psychiatrist | | - | - |
| | Physicians | | (96) | (31) |
| | Dentists | | - | - |
| | Mid Level Practitioner | | - | - |
| | Other Practitioners | | - | - |
| | Home Health | | - | - |
| | Lab and Radiology | | - | - |
| | Medical Supplies | | - | - |
| | Clinic Services | | - | - |
| | Ambulatory Surgery Center | | - | - |
| | Skilled Nursing | | - | - |
| | Prescription Drugs | | (271) | (88) |
| | Transportation | | - | - |
| | Premiums Collected | | | - |
| **Total Individual Plan** | | | $ (566) | $ (184) |
| | **College Students-Service Costs** | | $ - | $ - |
| **Total OHCA Program Costs** | | | $ 8,797,488 | $ 8,761,712 |
| **Administrative Costs** | | | | |
| | Salaries | $ (0) | $ 495,256 | $ 495,256 |
| | Operating Costs | 141 | 422 | 562 |
| | E&E Development Gainwell | - | - | - |
| | Contract - Gainwell | 189,915 | 192,528 | 382,443 |
| | | | - | |
| **Total Administrative Costs** | | $ 190,055 | $ 688,206 | $ 878,261 |
| **Total Expenditures** | | | | $ 9,639,973 |
| **Transfer to Fund 340 for Expansion Costs** | | | | $ 6,872,184 |
| **NET CASH BALANCE** | | $ 1,334,757 | $ 518,234 | $ 1,852,991 |

# OKLAHOMA HEALTH CARE AUTHORITY

## Combining Statement of Revenues, Expenditures and Changes in Fund Balance

## SFY 2025, For the Four Months Period Ending October 31, 2024

| | Administration Fund 200 | Supplemental Hospital Offset Payment Program Fund 205 | Quality of Care Fund 230 | Rate Preservation Fund 236 | Federal Deferral Fund 240 | Health Employee and Economy Act Fund 245 | Belle Maxine Hilliard Breast & Cervical Cancer Treatment (Tobacco) Fund 250 | Medicaid Program (Tobacco) Fund 255 | Ambulance Service Provider Access Payment Program Fund 270 | Medicaid Program Fund 340 | Clearing Account 1807B | Total Cash Balance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **OCTOBER Beginning Fund Balance:** | | | | | | | | | | | | |
| Prior year | 58,546,321 | 6,179,367 | 15,275 | 495,678,835 | 18,456,928 | 1,333,916 | - | - | - | 487,730,277 | 202,331,612 | 1,270,272,530 |
| Current year | (10,401,198) | 7,019,753 | (15,275) | 24,999,999 | 155,739 | 752,657 | - | - | - | (192,879,325) | 2,306,097 | (168,061,552) |
| Total | 48,145,123 | 13,199,120 | 0 | 520,678,834 | 18,612,667 | 2,086,572 | - | - | - | 294,850,953 | 204,637,709 | 1,102,210,978 |
| **OCTOBER Revenues:** | | | | | | | | | | | | |
| Prior year | 945,083 | - | - | - | - | 841 | - | - | - | 2,863,715 | - | 3,809,639 |
| Current year | 8,772,752 | 34,017 | 6,968,835 | - | 51,584 | 4,137,955 | 50,389 | 3,019,266 | - | 906,199,640 | 157,577,091 | 1,086,811,528 |
| Total | 9,717,835 | 34,017 | 6,968,835 | - | 51,584 | 4,138,796 | 50,389 | 3,019,266 | - | 909,063,355 | 157,577,091 | 1,090,621,167 |
| **OCTOBER Expenditures:** | | | | | | | | | | | | |
| Prior year | 3,061,131 | - | - | - | - | - | - | - | - | - | - | 3,061,131 |
| Current year | 15,310,107 | - | - | - | - | 2,444,491 | - | - | - | 1,146,272,769 | - | 1,164,027,367 |
| Total | 18,371,237 | - | - | - | - | 2,444,491 | - | - | - | 1,146,272,769 | | 1,167,088,498 |
| **Operating Transfers In** | | | | | | | | | | | | |
| Prior year | | | | | | | | | | | | |
| Current year | 6,427,467 | - | - | 8,333,333 | - | - | - | - | - | 205,302,501 | - | 220,063,301 |
| Total | 6,427,467 | - | - | 8,333,333 | - | - | - | - | - | 205,302,501 | - | 220,063,301 |
| **Account Receivables** | 411,550 | (90,808,702) | - | | | | | | - | (8,459,763) | | (98,856,915) |
| | 411,550 | (90,808,702) | - | - | - | - | - | - | - | (8,459,763) | - | (98,856,915) |
| **Operating Transfers Out** | | | | | | | | | | | | |
| Prior year | 4,020,721 | - | - | - | - | - | - | - | - | 11,583,333 | | 15,604,054 |
| Current year | - | 92,028,712 | 6,517,075 | - | - | 1,718,046 | 50,389 | 3,019,266 | - | - | 202,331,612 | 305,665,100 |
| Total | 4,020,721 | 92,028,712 | 6,517,075 | - | - | 1,718,046 | 50,389 | 3,019,266 | - | 11,583,333 | 202,331,612 | 321,269,154 |
| ***Change in CY Fund Balance*** | ***(10,511,086)*** | ***(84,974,943)*** | ***436,485*** | ***33,333,332*** | ***207,323*** | ***728,074*** | ***-*** | ***-*** | ***-*** | ***(227,649,953)*** | ***(42,448,423)*** | ***(330,879,190)*** |
| **Ending Fund Balance** | **41,486,917** | **12,013,127** | **451,760** | **529,012,167** | **18,664,251** | **2,062,831** | **-** | **-** | **-** | **259,820,469** | **159,883,188** | **1,023,394,710** |

# OKLAHOMA HEALTH CARE AUTHORITY

## HEALTHY ADULT PROGRAM EXPENDITURES - OHCA

## SFY 2025, For the Four Months Period Ending October 31, 2024

| OCTOBER Beginning Fund Balance: | FY 25 BUDGETED EXPENDITURES Full Year | FY 25 BUDGETED EXPENDITURES Year to Date | FY 25 ACTUAL EXPENDITURES OCTOBER | BUDGET VARIANCE (Over)/ Under |
|---|---|---|---|---|
| **OHCA MEDICAID PROGRAMS** | | | | |
| **Managed Care** | | | | |
| SoonerCare Choice | 744,566 | 248,189 | 241,772 | 6,416 |
| SoonerSelect Medical | 803,761,870 | 263,209,423 | 243,710,738 | 19,498,685 |
| SoonerSelect Dental | 38,506,682 | 12,631,503 | 12,622,254 | 9,250 |
| **Total Managed Care** | **843,013,118** | **276,089,115** | **256,574,764** | **19,514,351** |
| **Fee for Service** | | | | |
| **Hospital Services:** | | | | |
| Inpatient Acute Care | 151,971,955 | 58,090,666 | 45,943,567 | 12,147,099 |
| SHOPP - DPP | 370,492,235 | 185,246,117 | 185,246,117 | - |
| SHOPP - FFS | 58,263,548 | 32,446,187 | 52,596,617 | (20,150,430) |
| Outpatient Acute Care | 110,255,040 | 41,176,394 | 45,531,152 | (4,354,758) |
| **Total Hospitals** | **690,982,777** | **316,959,365** | **329,317,454** | **(12,358,089)** |
| **Behavioral Mental Health:** | | | | |
| Inpatient Services - DRG | 10,897,419 | 4,191,315 | 5,375,772 | (1,184,457) |
| Outpatient | - | - | - | - |
| **Total Behavioral Mental Health** | **10,897,419** | **4,191,315** | **5,375,772** | **(1,184,457)** |
| **Physicians & Other Providers:** | | | | |
| Physicians | 71,100,511 | 26,801,502 | 20,685,281 | 6,116,221 |
| Dentists | 9,781,932 | 3,383,525 | 3,561,308 | (177,783) |
| Mid-Level Practitioner | 57,708 | 19,976 | 23,191 | (3,215) |
| Other Practitioners | 7,649,348 | 2,898,050 | 3,550,655 | (652,604) |
| Home Health Care | 289,599 | 106,248 | 91,979 | 14,269 |
| Lab & Radiology | 9,356,944 | 3,267,468 | 1,904,594 | 1,362,874 |
| Medical Supplies | 7,767,915 | 2,922,166 | 2,355,394 | 566,772 |
| Clinic Services | 96,145,109 | 36,162,136 | 37,791,304 | (1,629,168) |
| Ambulatory Surgery | 2,121,472 | 783,366 | 497,148 | 286,218 |
| **Total Physicians & Other Providers** | **204,270,538** | **76,344,437** | **70,460,854** | **5,883,583** |
| **Misc Medical & Health Access Network** | **8,141** | **3,245** | **48,077** | (44,832) |
| **Transportation** | **20,187,251** | **6,910,667** | **6,415,572** | 495,095 |
| **Health Access Network** | **-** | **-** | **45,475** | (45,475) |
| **Provider Incentive Program** | **34,978,798** | **2,884,403** | **-** | 2,884,403 |
| **Prescription Drugs** | **290,521,155** | **103,285,735** | **101,168,211** | 2,117,523 |
| **Total OHCA Medicaid Programs** | **2,094,859,198** | **786,668,282** | **769,406,178** | **17,262,103** |

# 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 medical 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 September 9, 2024, Aetna Better Health of Oklahoma (ABHOK) 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:

| SoonerSelect Medical Requests to Change Service Provisions | | | | |
|---|---|---|---|---|
| **OHCA's CURRENT PROCESSING PROTOCOL** | **PROPOSED MODIFICALTION TO CLAIMS PROCESSING PROTOCOL** | **REASON FOR PROPOSED MODIFICATION-** | **ANTICIPATED IMPACT** | **OHCA DECISION** |
| **Pre-Pay Diagnosis Related Group Payments** | | | | |
| Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospital will be reimbursed the lesser of the billed charges or the DRG amount. In addition to the billed charges or DRG | All available information on file will be reviewed to validate the billed and/or derived DRG by clinically reviewing all billed diagnosis and procedure codes submitted on a claim.<br><br>If the available information on file does not support the billed and/or derived DRG ABH will reimburse the claim using the | Goal: To improve the accuracy of ABH's DRG (Diagnosis Related Grouping) payments by making sure the patient's medical record supports the claim submission. | Estimated Medicaid Savings of $7Million/annually. | APPROVE |

*Presented at the January 9, 2025, Medical Advisory Committee meeting*

| SoonerSelect Medical Requests to Change Service Provisions | | | | |
|---|---|---|---|---|
| **OHCA's CURRENT PROCESSING PROTOCOL** | **PROPOSED MODIFICALTION TO CLAIMS PROCESSING PROTOCOL** | **REASON FOR PROPOSED MODIFICATION-** | **ANTICIPATED IMPACT** | **OHCA DECISION** |
| payment, whichever is less, an outlier payment may be made to the hospital for very high-cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met. | DRG calculated upon review or deny of the claim.<br><br>Oklahoma state regulations will determine whether the claim is reimbursed at the calculated DRG rate or denied.<br><br>ICD-10 Guidelines for Coding and Reporting guidelines, as well as the UHDDS (Uniform Hospital Discharge Data Set) guidelines as referenced in the ICD-10 Guidelines for Coding and Reporting. | | | |

# SOONERSELECT VALUE-BASED PAYMENT PROGRAMS

OHCA Healthcare Quality & Performance

January 9th, 2024

# WHAT ARE VALUE-BASED PAYMENT PROGRAMS?

- These are arrangements/agreements/contracts between entities to align value and costs.

Simple types of VBP arrangements:

- Pay for reporting

- Pay for performance/Pay for quality

More complex types of VBP arrangements

- Upside Risks

- Downside Risks

- Quality benchmarks are set, and the contractors must meet the benchmarks to be rewarded.

- Benchmarks are available through the National Committee for Quality Assurance (NCQA)

# A CLOSER LOOK AT TYPES OF VBP PROGRAMS

- Pay for reporting:

This used to improve data quality. For instance, providers could be incentivized to report certain codes on their claims

- Pay for performance/Pay for quality:

One of the more common forms. Targets/benchmarks at set and providers must hit the target to get a bonus payment.

Upside and downside risks are more complex forms of VBP Programs

- Upside Risk:

Rewards providers for meeting quality and cost targets and providers aren't penalized if they don't meet targets. Here providers do earn shared savings if they meet/exceed the set targets.

- Downside Risks:

Providers are held responsible for meeting cost & quality targets. They can assume full risk or share risk with payers. If providers don't meet the set targets, they absorb a 100% of losses under a full risk arrangement.

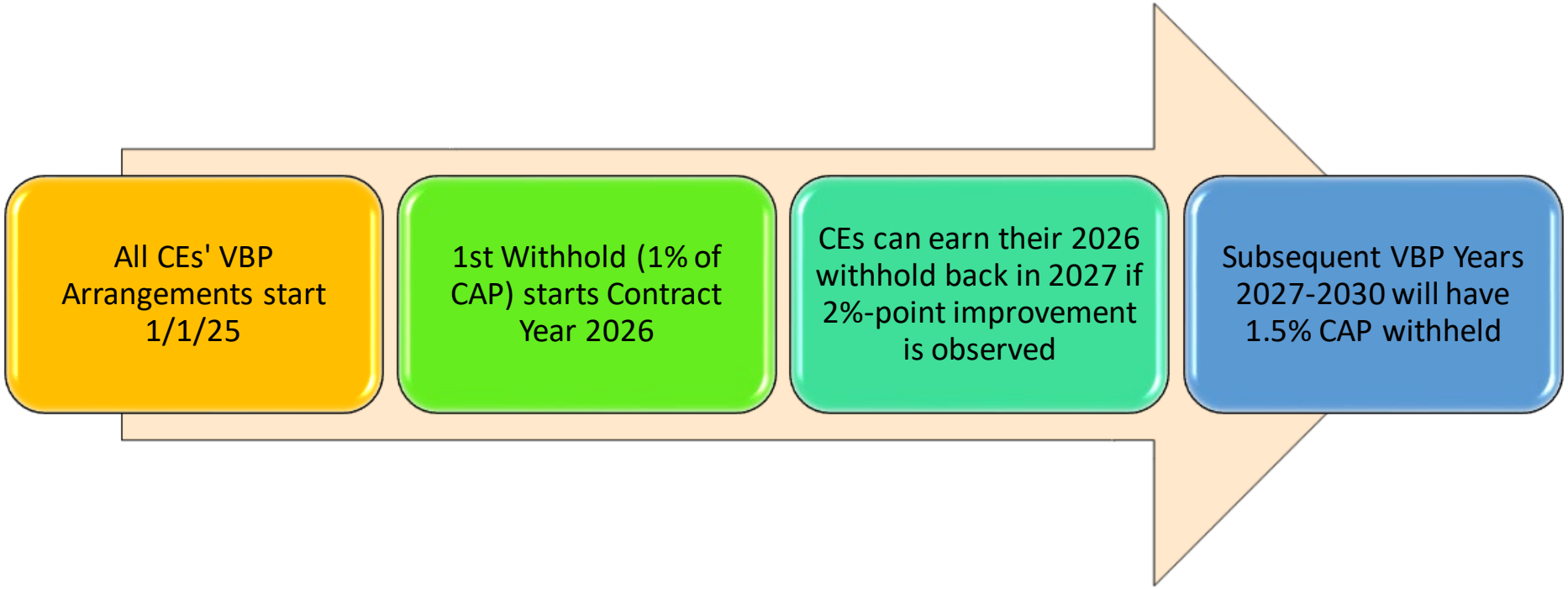
# OHCA'S VBP PROGRAM

- OHCA's VBP Program is a Quality Withhold Program.
- OHCA will withhold a percentage of the CEs' capitation payments annually.
- First withhold year will be Contract Year 2026; **1% of CEs CAP Payments will be withheld**
- For subsequent years, **1.5% of CAP will be withheld**
- From Year 1 to 2, CEs must attain a 2%-point improvement for 12 quality measures to recoup withheld amount. **So, 2025 will be the baseline year; 2026 the comparison year; 2027 is the recoupment year if improvement is achieved.**
- **OHCA reserves the right to set more aggressive targets in subsequent years**

# HEALTH PLANS' VBP PROGRAMS

- All CEs VBP programs will launch January 1st, 2025.
- PCMH care coordination payments will continue through June 30th, 2025
- CEs' value-based payments will start quarter 3 of 2025.
- CEs will offer a menu of VBP options for providers to choose from
- Provider participation in VBP programs  is voluntary

# SOONERSELECT VBP TRANSITION TIMELINE



# VBP METHODOLOGY REVIEW PROCESS

## Requested updated SEL-1616 Reports: Value Based Payment Methodology Reports

- CEs submitted updated 1616s to SoonerSelect/OHCA Quality
- Reviewed in conjunction with Guidehouse

## Provided Feedback to CEs

- OHCA Quality requested answers to questions following reviews
- Established weekly meetings with each CE to discuss their submitted VBP methodologies
- Requested a resubmission of the 1616s updated with answers to questions following the review.

## Approval of Methodologies

- Reviewed the updated 1616s
- Granted approvals to all CEs after several rounds of reviews.
- Will continue discussions on program progress in our scheduled OHCA/CE Quality meetings starting in January 2025

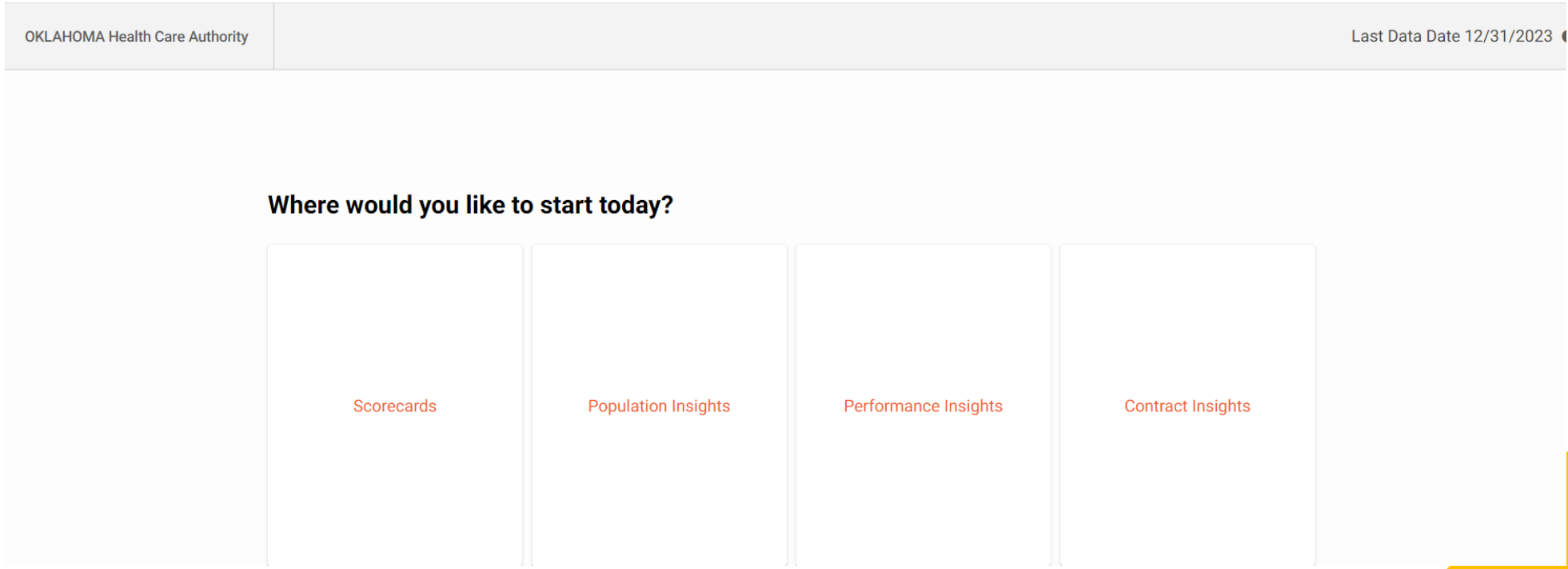
# PLAN SPECIFIC INFORMATION ON VBP ARRANGEMENTS

| VBP Elements | Aetna | Humana | OCH-Medical | OCH-CSP |
|---|---|---|---|---|
| 1/1/25 Start Date | Yes | Yes | Yes | Yes |
| PCMH Care Coordination Payments till 6/30/25 | Yes | Yes | Yes | Yes |
| VBP Methodology Approved | Yes | Yes | Yes | Yes |
| VBP Contract/Agreement | Yes | Yes | No (all providers will be enrolled with an opt-out option) | No (all providers will be enrolled with an opt-out option) |
| VBP Provider Participation Criteria | Providers with minimum of 50 patients on panel | Minimum of 30 patients on panel | No criteria | No criteria. |
| Quality measures from withhold program | Yes | Yes | Yes | Yes |
| 50$^{th}$ Percentile NCQA Quality Compass | Yes | Yes | X (different levels of compensation for 50$^{th}$, 75$^{th}$ and 95$^{th}$ percentiles) as providers can earn more as they hit higher percentiles on the measure in question. | X (different levels of compensation for 50$^{th}$, 75$^{th}$ and 95$^{th}$ percentiles) as providers can earn more as they hit higher percentiles on the measure in question. |
| VBP Communication Plan | Will payout in Q3 of 2025 for Q1 2025 performance and pay quarterly going forward. | Will payout bi-annually: May/Oct. Humana will pay on mid-year reporting performance (1/1 - 6/30) in Q4 of 2025 (Oct 2025) and on full calendar-year reporting (1/1 – 12/31) in May of the following year. | OCH will payout for Q1 (Jan – Mar 2025) in Q3 (July - Sept) and subsequent payments will be quarterly. | OCH will payout for Q1 (Jan – Mar 2025) in Q3 (July - Sept) and subsequent payments will be quarterly. |
| Change Management | CEs will collaborate with OHCA and other CEs to communicate transition to VBP to providers | | | |

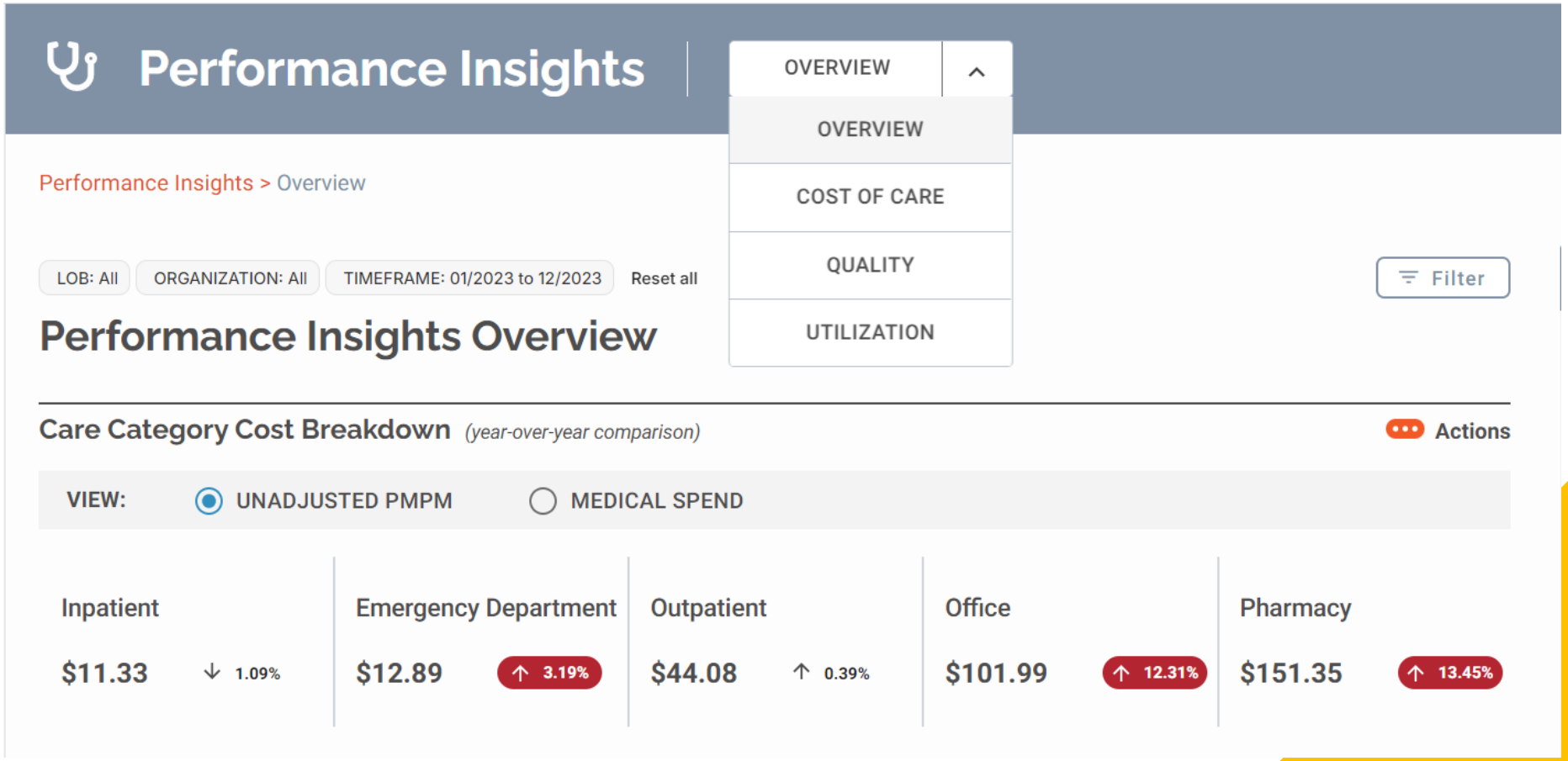
# GRAYMATTER

- Data analytics platform called CoreTechs
- Ingest encounter data and provide analytics on quality
- Allows OHCA to track progress on quality metrics
- Provides a tool to validate CE's performance in the Quality Withhold Program – Core Techs will provide a rate for each quality measure in the withhold program for each CE.
- There should be little difference between the data the plans submit and what Core Techs provides.

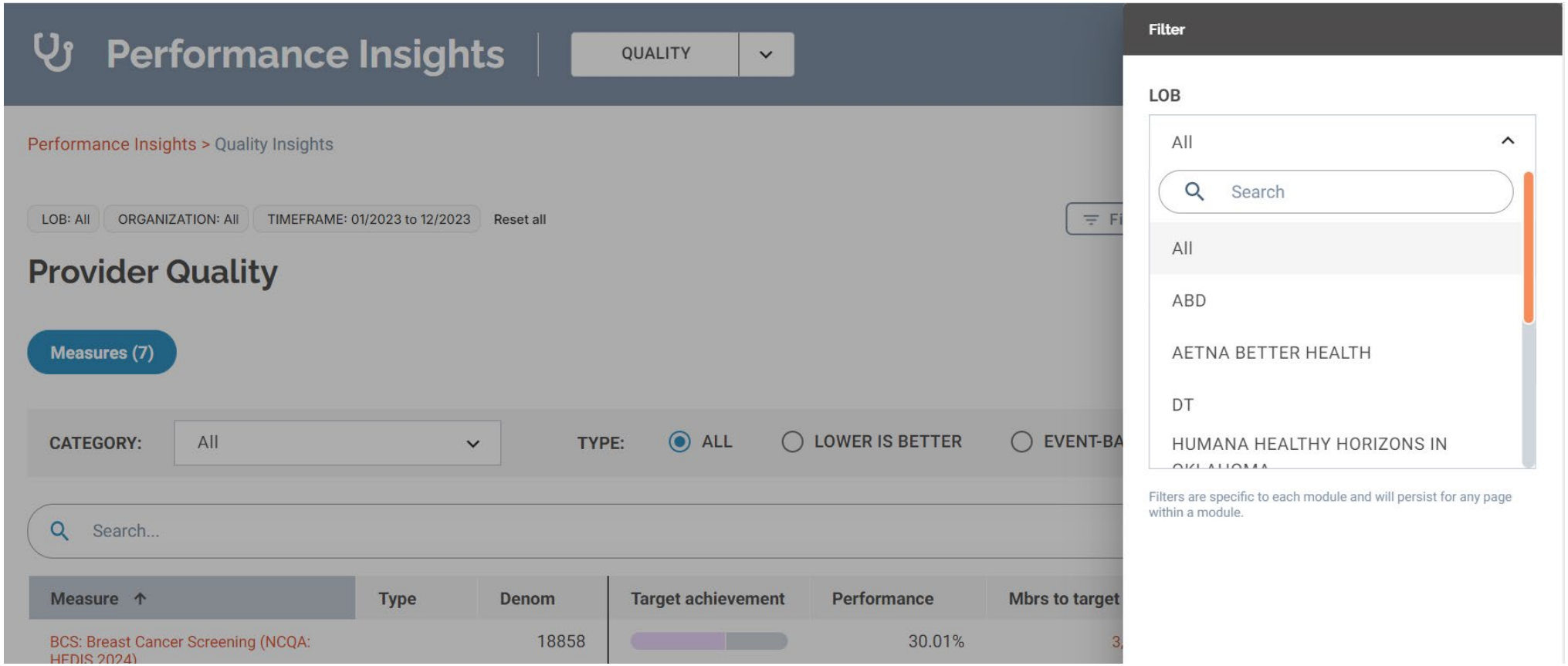
# CORETECHS


OKLAHOMA Health Care Authority
Last Data Date 12/31/2023
Where would you like to start today?
Scorecards
Population Insights
Performance Insights
Contract Insights

# CORETECHS


Performance Insights
OVERVIEW
OVERVIEW
COST OF CARE
QUALITY
UTILIZATION
Performance Insights > Overview
LOB: All
ORGANIZATION: All
TIMEFRAME: 01/2023 to 12/2023
Reset all
Filter
Performance Insights Overview
Care Category Cost Breakdown (year-over-year comparison)
Actions
VIEW:
UNADJUSTED PMPM
MEDICAL SPEND
Inpatient
$11.33
1.09%
Emergency Department
$12.89
3.19%
Outpatient
$44.08
0.39%
Office
$101.99
12.31%
Pharmacy
$151.35
13.45%

# CORETECHS


Performance Insights
QUALITY
Performance Insights > Quality Insights
LOB: All
ORGANIZATION: All
TIMEFRAME: 01/2023 to 12/2023
Reset all
Provider Quality
Measures (7)
CATEGORY:
All
TYPE:
ALL
LOWER IS BETTER
Search...
Measure
Type
Denom
Target achievement
Performance
Mbrs to target
BCS: Breast Cancer Screening (NCQA:
18858
30.01%
Filter
LOB
All
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ABD
AETNA BETTER HEALTH
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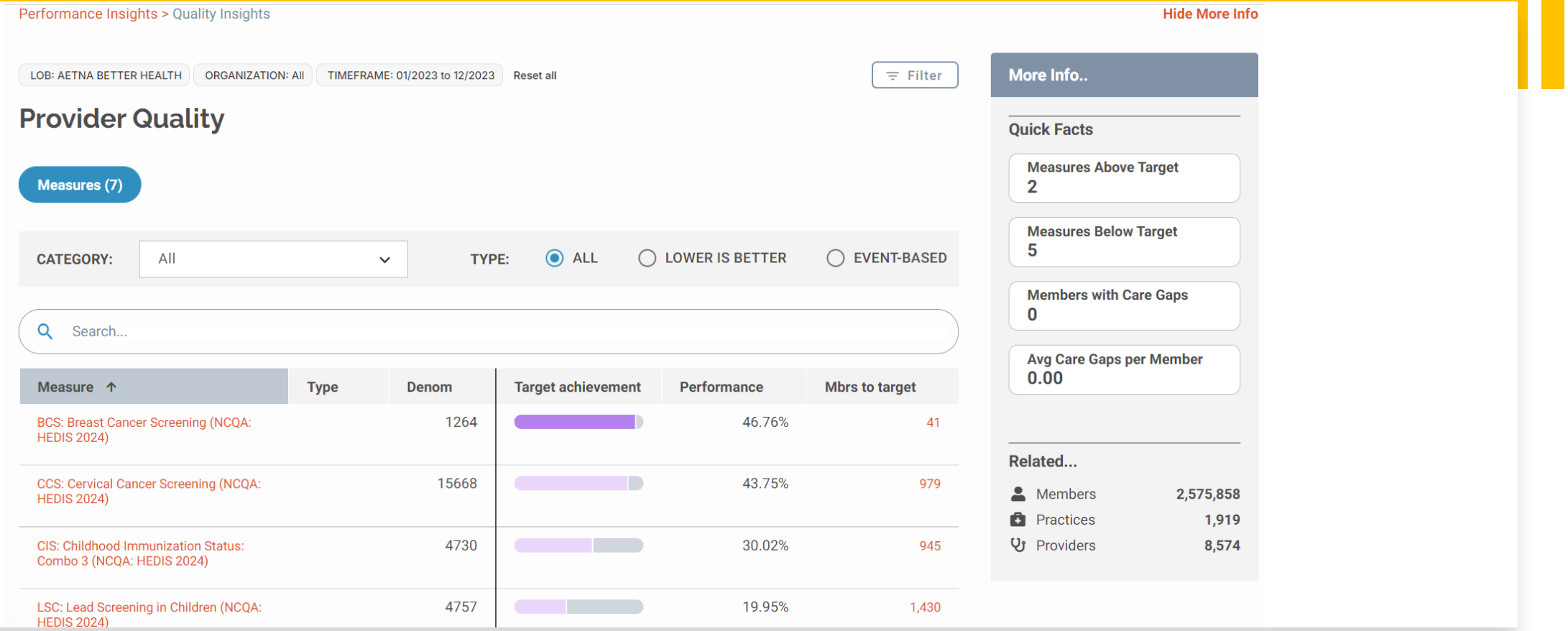
HUMANA HEALTHY HORIZONS IN
Filters are specific to each module and will persist for any page within a module.

# CORETECHS


Performance Insights > Quality Insights
Hide More Info
LOB: AETNA BETTER HEALTH
ORGANIZATION: All
TIMEFRAME: 01/2023 to 12/2023
Reset all
Filter
Provider Quality
Measures (7)
CATEGORY:
All
TYPE:
ALL
LOWER IS BETTER
EVENT-BASED
Search...
Measure
Type
Denom
Target achievement
Performance
Mbrs to target
BCS: Breast Cancer Screening (NCQA: HEDIS 2024)
1264
46.76%
41
CCS: Cervical Cancer Screening (NCQA: HEDIS 2024)
15668
43.75%
979
CIS: Childhood Immunization Status: Combo 3 (NCQA: HEDIS 2024)
4730
30.02%
945
LSC: Lead Screening in Children (NCQA: HEDIS 2024)
4757
19.95%
1,430
More Info..
Quick Facts
Measures Above Target
2
Measures Below Target
5
Members with Care Gaps
0
Avg Care Gaps per Member
0.00
Related...
Members
2,575,858
Practices
1,919
Providers
8,574

# QUESTIONS & ANSWERS

OKLAHOMA
Health Care Authority

# GET IN TOUCH


4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

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

**January 9, 2025 MAC**
**Proposed Rule Amendment Summary**

**These proposed PERMANENT rules were previously presented for Tribal Consultation and were subject to a 30-day public comment period from Dec. 2 through Jan. 6, 2025**

**The agency is requesting the effective date to be within Sept. of 2024, contingent upon receiving legislature and gubernatorial approval.**

A. **APA WF # 24-11 Doula Certifying Organization Criteria —** The proposed policy includes OHCA-developed minimum criteria that doula certifying organizations must meet to be State recognized. The proposed criteria address doula specialty certifications offered by the organization, frequency of recertification, training modalities, support experience required and references for prospective doulas, and practice guidelines and standards (including ethics guidelines and a grievance/disciplinary policy). OHCA will only contract with doulas who are certified by a recognized certifying organization meeting the minimum criteria.

   **Budget Impact:** Budget neutral.

B. **APA WF # 24-13 Program of All-Inclusive Care for the Elderly (PACE) Policy –** The proposed rule changes clarify the PACE organization's responsibilities in addressing housing insecurity for a potential or current participant, requirements of the involuntary disenrollment process, and participant use of assisted living.

   **Budget Impact:** Budget neutral.

C. **APA WF # 24-17A&B Electronic Visit Verification (EVV) Revisions —** Proposed revisions align agency policy with the 21st Century Cures Act by requiring the use of EVV by home health agencies. Live-in caregivers are added as a provider for personal care services and must also adhere to EVV requirements. Additionally, language is updated to reflect the name change for Oklahoma Human Services and the department who oversee the program.

   **Budget Impact:** Budget neutral.

D. **APA WF # 24-28 Crisis Intervention Services Limitations —** The OHCA, in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), will update crisis intervention policy to match current business practice. Hard limits on these services will be removed from policy to ensure that all members who utilize crisis intervention services have adequate treatment.

   **Budget Impact:** Budget neutral.

E. **APA WF # 24-29 Diagnosis Clarification for Inpatient Psychiatric Services —** Proposed policy revisions remove autism spectrum disorder (ASD) and intellectual disability (ID) as primary presenting diagnoses for admission into inpatient psychiatric

services. A diagnosis of ASD or ID cannot be exclusionary and may be present and documented as coexisting with other qualifying conditions for admission as the secondary diagnosis. The primary presenting diagnosis must be consistent with the primary reason for admission. These changes shall not be used to preclude or exclude any member with ASD or ID.

**Budget Impact:** Budget neutral.

F. **APA WF # 24-30 Updates to Residential Substance Use Disorder (SUD) Policy —** OHCA, in collaboration with ODMHSAS, proposes modifications to residential SUD policies which currently requires physician supervision for American Society of Addiction Medicine (ASAM) level 3.7 of care. This update allows for RN supervision and adds licensed independent practitioners (physician, APRN, and PA) as providers of this level of care. Changes clarify the time frame for assessments and progress notes, when service plans and reviews are valid, the signature requirements, and removes specific assessment tool terminology for adolescents.

   **Budget Impact:** Budget neutral.

G. **APA WF 24-31 A&B Removal of Outdated Language —** OHCA is updating policy to replace outdated terminology with “individuals with intellectual disabilities” or “intellectual disability.”

   **Budget Impact:** Budget neutral.

H. **APA WF # 24-32 Removing Certain Drugs from 340b Program —** These rule revisions seek to remove certain drugs and therapies from the 340b Drug Pricing Program. The 340b program is a federal initiative that allows health care organizations to purchase certain drugs directly from pharmaceutical manufacturers at a discount. One restriction on this program is that no rebates can be collected from any drug or therapy purchased under the program, including supplemental rebates. These revisions prohibit purchasing drugs under the 340b program if they are in a supplemental rebate agreement.

   **Budget Impact:** Budget neutral.

I. **APA WF # 24-33 In Lieu of Service or Setting (ILOS) —** Proposed revisions align policy with the Managed Care Access, Finance, and Quality Final Rule as it relates to an ILOS. Revisions add the definition of an ILOS when provided by a managed care contracted entity (CE) as a substitute for a covered service or setting under the state plan. Additionally, an ILOS must be approvable as a service or setting through a 1915(c) Home and Community Based Service waiver or a state plan amendment. Policy revisions also clarify that an approved ILOS is a component of the capitation rate paid to SoonerSelect CEs.

   **Budget Impact:** Budget neutral.

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 114. DOULA SERVICES

### 317:30-5-1216. Eligible providers

(a) **Provider requirements.** At minimum, providers must:

(1) Be eighteen (18) years of age;

(2) Obtain and maintain a National Provider Identifier (NPI); and

(3) Use the taxonomy number required by the State.

(b) **Certifications.** ~~Providers~~At minimum, providers must possess one of the following certifications:

(1) Birth doula;

(2) Postpartum doula;

(3) Full-spectrum doula; or

(4) Community-based doula.

~~(b)~~(c) **Certifying organization.** Providers must be certified by one of the State's recognized certifying organizations found at www.oklahoma.gov/ohca/. Certifying organizations must meet the criteria in this subsection to be a recognized certifying organization. Certifying organizations interested in becoming a recognized certifying organization should complete the Doula Certifying Organization Application, Form DCOA, (found at https://oklahoma.gov/ohca/providers/forms.html) and follow the instructions on the form for submission.

(1) **Records.** The certifying organization must maintain a registry of all doulas it has certified, including those who are not practicing or whose certifications have expired. The certifying organization must have a process for prospective clients to verify the certification of a doula.

(2) **Certification Discipline.** The certifying organization must offer certification in at least one of the following disciplines:

(A) Birth doula;

(B) Postpartum doula;

(C) Full-spectrum doula; or

(D) Community-based doula.

(3) **Training.** The certifying organization may provide training online, in-person or a combination of both.

(A)The certifying organization must require a minimum of two in-person birth supports and two postpartum visits with a certified doula from the organization.

(B) The certifying organization must require a prospective doula to complete all training requirements within one (1) year of training initiation.

(C) The certifying organization must require and verify that prospective doulas are CPR-certified.

(D) The certifying organization must provide HIPAA training to prospective doulas.

(4) **References.** The certifying organization must require prospective doulas to obtain at least two professional references for certification. At least one reference must be from a client.

(5) **Continuing Education.** The certifying organization must provide Continuing Education (C.E.) training in birth support and postpartum support. The certifying organization may also approve C.E. experiences offered by other organizations for credit towards recertification.

(6) **Recertification.** The certifying organization must require all doulas to be recertified at least every three (3) years. Lifetime certifications are not permissible. Certifying organizations may require recertification more frequently than every three (3) years. The certifying organization must implement the following minimum requirements for recertification.

(A) Certifying organizations must require that all doulas complete a minimum of three (3) C.E. experiences to be eligible for recertification. The C.E. experiences may contain any combination of birth support and postpartum support education. The minimum three (3) C.E. experiences must be completed within the doula's current certification period to be eligible for recertification.

(B) Certifying organizations must require and reverify that doulas maintain CPR certification to be eligible for recertification.

(C) Certifying organizations must require that doulas complete HIPAA training during each certification period to be eligible for recertification.

(7) **Practice Guidelines.** The certifying organization must have the following policies. A copy of each must be submitted along with the application.

(A) Standards of practice;

(B) Code of ethics and conduct;

(C) Social media policy; and

(D) Grievance and disciplinary policy.

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

## SUBCHAPTER 18. PROGRAMS FOR THE ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

### 317:35-18-4. Provider regulations

(a) The provider must comply with provisions of this Subchapter, ~~and~~ the regulations in 42 CFR, Part 460, and all applicable local, state, and federal regulations. The provider must comply with all evaluation, monitoring, oversight, and other activities of the State Administering Agency (OHCA) as described in 42 CFR, Part 460.

~~(b) The provider agency must be licensed by the State of Oklahoma as an adult day care center.~~

~~(c) The provider must meet all applicable local, state, and federal regulations.~~

~~(d)~~(b) The provider must maintain an inquiry log of all individuals requesting Programs of All-Inclusive Care for the Elderly (PACE) services. This log will be available to the OHCA at all times. The log must include:

(1) type of contact;
(2) date of contact;
(3) name and phone number of the individual requesting services;
(4) name and address of the potential participant; and
(5) date of enrollment, or reason for denial if the individual is not enrolled.

(c) Pursuant to 42 CFR 460.70, any entity contracted by the provider to render PACE benefits must comply with the provisions of this Subchapter, the regulations in 42 CFR Part 460, and any other local, state, and federal regulations applicable to the provider.

(d) OHCA reserves the right to deny a provider's application for a new or renewed contract or terminate a contract with a provider as described in OAC 317:30-3-19.3 and OAC 317:30-3-19.5.

(e) PACE programs are license-exempt only when they provide services exclusively to PACE participants.

### 317:35-18-5. Eligibility criteria

(a) To be eligible for participation in Programs of All-Inclusive Care for the Elderly (PACE), the applicant must:

(1) Be age fifty-five (55) years or older;
(2) Live in a PACE service area;
(A) Applicants are permitted to utilize assisted living. The applicant must have a landlord-tenant relationship with the assisted living facility. Should the applicant become a PACE participant, the participant must maintain the landlord-tenant relationship with the assisted living facility. The PACE organization cannot be involved in payment for room and board from the participant to the assisted living facility. The PACE organization may provide supplemental payments to an assisted living facility outside of the room and board payments paid by the participant.
(3) Be determined by the state to meet nursing facility level of care; and
(4) Be determined by the PACE interdisciplinary team (IDT) as able to be safely served in the community at the time of enrollment. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:

(A) Notify the applicant in writing of the reason for the denial;
(B) Refer the applicant to alternative services as appropriate;
(C) Maintain supporting documentation for the denial and notify the Centers for Medicare and Medicaid Services and the Oklahoma Health Care Authority (OHCA) of the denial and submit that documentation to the OHCA for review; and
(D) Advise the applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for SoonerCare capitated payments, the individual must:
(1) Meet categorical relationship for the aged, blind, or disabled [refer to Oklahoma Administrative Code (OAC) 317:35-5-4];
(2) Be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services (OKDHS)
(3) Be eligible for SoonerCare State Plan services;
(4) Meet the same financial eligibility criteria as set forth for the SoonerCare ADvantage program per OAC 317:35-17-10 and 317:30-17-11; ~~and~~
(5) Meet appropriate medical eligibility criteria~~.~~; and
(6) Receive all covered services for which they are eligible solely through the PACE Organization as required by 42 CFR 460.90.

(c) The nurse designee makes the medical determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) ~~Part I,~~ Part III, and other available medical information.
(1) When PACE services are requested:
(A) The PACE nurse or ~~OKDHS~~Oklahoma Human Services (OHS) nurse is responsible for completing the UCAT assessment.
(B) The PACE Organization intake staff is responsible for aiding the PACE enrollee in contacting OKDHS to initiate the financial eligibility application process.
(2) The nurse completes the UCAT, Part III visit with the PACE enrollee, in the participant's home, within ten (10) days of receipt of the referral for PACE services.
(3) The nurse sends the UCAT, Part III to the designated OHCA nurse staff member for review and level of care determination.
(4) A new medical level of care determination may be required when a member requests any of the following changes in service programs:
(A) From PACE to ADvantage;
(B) From PACE to State Plan Personal Care Services;
(C) From Nursing Facility to PACE;
(D) From ADvantage to PACE if previous UCAT was completed more than six (6) months prior to member requesting PACE enrollment; ~~or~~
(E) From PACE site to PACE site~~.~~; or
(F) From PACE to Nursing Facility.

(d) To obtain and maintain eligibility, the individual must agree to accept the PACE providers and its contractors as the individual's only service provider. The individual may be held financially liable for services received without prior authorization except for emergency medical care.

**317:35-18-8. Enrollment**

(a) The PACE provider determines whether the applicant meets PACE enrollment requirements.
(b) The enrollment effective date is the first day of the month after the provider receives the signed enrollment form.

(c) During the initial eligibility determination and prior to enrollment, the provider must assess the prospective participant's housing status to determine if they are housing insecure. If the prospective participant is determined to be housing insecure and is enrolled, the participant's housing insecurity must be addressed in their plan of care. If the participant's housing insecurity has not improved after two (2) months of enrollment, the provider must disenroll the participant according to the involuntary disenrollment procedures defined in 317:35-18-10. For the purposes of this requirement, OHCA considers housing insecurity to be the lack of stable occupancy of a decent, safe, and affordable housing unit.

~~(c)~~(d) Enrollment continues until the participant's death, regardless of changes in health status, unless either of the following actions occur:

(1) The participant voluntarily disenrolls and/or elects to transfer to other eligible PACE program.

(2) The participant is involuntarily disenrolled.

**317:35-18-10. Disenrollment (voluntary and involuntary)**

(a) A participant may voluntarily disenroll from PACE at any time without cause however, the effective date of disenrollment must be the last day of the month that the participant elects to disenroll.

(b) A participant may be involuntarily disenrolled for any of the following reasons:

(1) The participant/caregiver or guardian fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.

(2) The participant/caregiver or guardian engages in disruptive or threatening behavior, as described in subsection (c) of this section.

(3) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The participant is determined to no longer meet the SoonerCare nursing facility level of care requirements and is not deemed eligible.

(5) The PACE program agreement with CMS and OHCA is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

(c) Requirements for involuntary disenrollment due to disruptive or threatening behavior.

(1) For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:

(A) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or

(B) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

(2) If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:

(A) The reasons for proposing to disenroll the participant; and

(B) All efforts to remedy the situation.

~~(c) A participant may be involuntarily disenrolled for disruptive or threatening behavior. For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:~~

~~(1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others;~~

~~or~~

~~(2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.~~

~~(d) If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:~~

~~(1) The reasons for proposing to disenroll the participant.~~

~~(2) All efforts to remedy the situation.~~

~~(e)~~(d) A participant may be disenrolled involuntarily for noncompliant behavior.

(1) PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others.

(2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

~~(f)~~(e) Before an involuntary disenrollment is effective, OHCA will review the participant's medical record and determine in a timely manner ~~that~~if the PACE organization has adequately documented acceptable grounds for disenrollment. Once OHCA confirms receipt of the involuntary disenrollment form from the PACE organization, the PACE organization must submit the following documentation within fourteen (14) days.

(1) A justification summary for involuntary disenrollment;

(2) Documentation of all efforts made to resolve the issue(s) underlying the request for involuntary disenrollment and the anticipated date of involuntary disenrollment;

(3) The two (2) most recent assessments by the Interdisciplinary Team (IDT);

(A) If the participant has not been enrolled long enough to have completed two IDT assessments, the participant's UCAT should be submitted.

(4) The two (2) most recent IDT care plans;

(5) Initial and most recent Nursing Level of Care (NF LOC) assessments;

(A) The PACE organization must complete a new level of care assessment for a disenrolling participant whose most recent assessment was completed more than 12 months prior to the anticipated date of disenrollment.

(B) The PACE organization must complete a new level of care assessment for a disenrolling participant who is Deemed Continued Eligibility/waived.

(6) Any related assessments and documentation by specialists relevant to the criteria for involuntary disenrollment;

(7) A list of the participant's medications; and

(8) A transition plan indicating how care and services will be coordinated between the PACE organization and the participant's new providers as PACE enrollment ends and new provider enrollment begins.

(f) Involuntary disenrollment procedures for PACE organizations.

(1) **30-Day Notice of Disenrollment.** Upon authorization by OHCA of the involuntary disenrollment, the PACE organization shall give a "30-Day Notice of Disenrollment" to the participant. The Involuntary Disenrollment is effective the first day of the next month that begins 30 days after the day the PACE Organization sends notice of disenrollment to the participant.

(A) The notification shall include information about the right to appeal and how to

access the appeal process.

(B) The participant shall be advised that, in light of an adverse appeal determination, the participant may be responsible for payment.

(2) **Options counseling.** Upon authorization of an involuntary disenrollment, the PACE organization shall provide face-to-face options counseling with the participant.

(A) If the participant declines a face-to-face meeting, the counseling may occur via telephone.

(B) If unable to contact the participant/participant representative, the PACE organization shall specifically document, in the participant's record, all efforts to engage the participant/participant representative in options counseling.

(C) As part of options counseling, the PACE organization shall make reasonable efforts to provide the participant with the following information:

(i) If the participant withdraws from PACE without enrollment into a Medicaid waiver program, such as ADvantage waiver services, this may result in loss of eligibility for Medicaid State Plan services due to the financial eligibility requirement;

(ii) The PACE and/or State Plan services that will be lost or unavailable as a result of the involuntary withdrawal;

(iii) What the participant must do to remain eligible to receive SoonerCare, if applicable;

(iv) Other services or programs for which the participant may be eligible, including information about contacting the Oklahoma Human Services (OHS) and Community Living, Aging, and Protective Services (CAP);

(v) How to access PACE services in the future; and

(vi) The withdrawal process, timeframes, and outcomes and the need for the participant to sign applicable consent forms.

(3) **Disenrollment documentation.** The PACE organization shall complete the following applicable disenrollment forms and documentation requirements with the participant and shall submit them to OHCA.

(A) Disenrollment form;

(B) Nursing facility level of care (NC LOC) status;

(i) The PACE organization must complete a new level of care assessment for a disenrolling participant whose most recent assessment was completed more than 12 months prior to the anticipated date of disenrollment.

(ii) The PACE organization must complete a new level of care assessment for a disenrolling participant who is Deemed Continued Eligibility/waived.

(C) The two (2) most recent assessments by the Interdisciplinary Team (IDT); and

(D) The two (2) most recent IDT care plans.

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

## SUBCHAPTER 3. GENERAL PROVIDER POLICIES

## PART 1. GENERAL SCOPE AND ADMINISTRATION

### 317:30-3-34. Electronic visit verification (EVV) system

An EVV system is a telephone-based, computer-based, or other electronic-based system that verifies and documents the time and location of services requiring an in-home visit, including, but not limited to, personal care services (PCS), home health care services (HHCS), self-directed services, and live-in caregivers, in accordance with an approved prior authorization or individual plan of care, and pursuant to Title 42 of the United States Code, Section (§) 1396b(l).

(1) **Verification requirements.** An EVV system must verify the following for in-home or community services:

(A) Type of service performed (service code and any applicable modifier);

(B) Date of service;

(C) SoonerCare member identification number of the individual receiving the service;

(D) Unique vendor identification number for the individual providing the service (service provider);

(E) Location where service starts and ends; and

(F) Time the service starts and ends.

(2) **Services requiring EVV system use.** An EVV system must be used for ~~personal care services~~PCS, HHCS, self-directed services, and live-in caregivers, as defined by Oklahoma Administrative Code (OAC) 317:35-15-2.

(3) **Services not requiring EVV system use.** When services are provided through home and community-based waivers, EVV is not required if those services are provided in:

(A) Combination with community residential supports, per Oklahoma Administrative Code (OAC) 340:100-5-22.1;

(B) Combination with group home services, per OAC 340:100-6; or

(C) Congregate settings where twenty-four (24) hour service is available; ~~or~~

~~(D) Settings where the member and service provider live in the same residence.~~

(4) **Provider requirements.** Providers are required to use an OHCA authorized and approved EVV system or aggregator. Providers may use the designated statewide EVV system, or their own EVV compliant system. A provider of ~~personal care services~~PCS, HHCS, self-directed services, and live-in caregivers using an EVV system must:

(A) Comply with all applicable federal and state laws and regulations, including, but not limited to, HIPAA privacy and security law, as defined in Section 3009 of the Public Health Service Act; required reporting of abused and/or neglected children, adolescents, and vulnerable adults [Section (§) 1-2-101 of Title 10A of the Oklahoma Statutes (O.S.) and 43A O.S. § 10-104]; and OAC 317:30-3-4.1, Uniform Electronic Transaction Act;

(B) Adopt internal policies and procedures regarding the EVV system;

(C) Ensure that employees are adequately trained on the EVV system's proper use, and make available to them real-time technical resources and support, such as a help desk or call center information;

(D) Ensure employees are adequately trained to properly engage the personal care agency's backup system when the EVV system is not available; and

(E) Ensure that the system:

(i) Accommodates members and service providers with hearing, physical, or visual impairments;

(ii) Accommodates multiple members and/or service providers in the same home or at the same phone number, as well as multiple work shifts per member per day;

(iii) Supports the addition or deletion of members, service providers, and health care services, at any time during the month, as authorized by the OHCA and/or the Oklahoma ~~Department of~~ Human Services ~~(OKDHS)~~(OHS);

(iv) Notifies supervisory staff at the personal care agency of any untimely or missed shifts, or any other deviation in scheduled care;

(v) Documents the existence of and justification for all manual modifications, adjustments, or exceptions after the service provider has entered or failed to enter the information in paragraph (1), above; and

(vi) Has the ability to respond to requests for records or documentation in the timeframe and format requested by OHCA.

(F) Be capable of retrieving current and archived data to produce summary reports of the information verified in Paragraph (1), above, as well as the information documented in (3)(E)(vi), above;

(G) Maintain reliable backup and recovery processes that ensure all data is preserved in the event of a system malfunction or disaster situation;

(H) Retain all data regarding the delivery of health care services for a minimum of six (6) years; and

(I) Establish a process to deactivate an employee's access to the EVV or designated system records upon termination of the designated employee's employment.

(5) **Claims reimbursement.** SoonerCare will not pay a claim for reimbursement unless the data is from an OHCA authorized and approved EVV system or aggregator; and includes all of the EVV verification requirements [refer to (1)A through F] of this section:

(A) Corresponds with the health care services for which reimbursement is claimed; and

(B) Is consistent with any approved prior authorization or individual plan of care.

(6) **Program integrity.** Paid claims may be subject to retrospective review and recoupment, as appropriate, in accordance with OAC 317:30-3-2.1.

(7) **Procedures for EVV system failure or EVV system unavailability.** The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of the EVV system failure, the provider documents the specified data in paragraph (1), above, in accordance with internal backup policies and procedures. This documentation is sufficient to account for in-home services. The personal care agency's backup procedures are only permitted when the EVV system is unavailable. For complete EVV system outages, providers would need to enter the specified data in paragraph (1), above, via web claim once the system is back online.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

**317:30-5-764. Reimbursement**

(a) Rates for Waiver services are set in accordance with the rate-setting process by the State Plan Amendment and Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority (OHCA) Board.

(1) The rate for Nursing Facility (NF) respite is set equivalent to the rate for routine level of care NF services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health is set equivalent to the rate established by the Oklahoma ~~Department of~~ Human Services ~~(OKDHS)~~OHS for equivalent services provided for the ~~OKDHS~~OHS Adult Day Service Program that requires providers have equivalent qualifications.

(3) The rate for units of home-delivered meals is set equivalent to the rate established by the OHS~~OKDHS~~ for the equivalent services provided for the ~~OKDHS~~OHS Home-Delivered Meals Program that require providers having equivalent qualifications.

(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate that requires providers have equivalent qualifications.

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(6) Consumer-Directed Personal Assistance Services and Supports (CD-PASS) rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the items listed in (A) B (C) of this paragraph.

(A) The IBA Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The Personal Care (PSA) and Personal Care Advanced Supportive/Restorative (APSA) service unit rates are calculated by the ~~OKDHSAging Services (AS)~~OHS Community, Aging and Protective Services (CAP) during the CD-PASS service eligibility determination process. ~~OKDHS AS~~OHS CAP sets the PSA and APSA unit rates at a level that is not less than eighty percent (80%) and not more than ninety-five percent (95%) of the comparable PSA or APSA service rates. The allocation of portions of the PSA and/or APSA rates to cover salary, mandatory taxes, and optional benefits including Worker's Compensation insurance, when available, is determined individually for each member using the CD-PASS IBA Expenditure Accounts Determination Process.

(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. When the member's need for services changes due to a change in health/disability status or a change in the level of support available from other sources to meet needs, the case manager, based upon an updated assessment, amends the person-centered service plan to increase CD-PASS service units appropriate to meet additional member need. ~~OKDHS AS~~OHS CAP, upon favorable review, authorizes the amended person-centered service plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member with assistance from the Financial Management Service, reviews and revises the IBA

Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(7) Three (3) per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL) and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 times the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 times the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 times the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by Uniform Comprehensive Assessment Tool, Part III (UCAT III) assessment by the member's Advantage case manager employed by a case management agency independent of the Assisted Living Services provider. ADvantage payment is not made for twenty-four (24) hour skilled care in an assisted living center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day health or environmental modifications to a member while receiving assisted living services since these services are integral to and inherent in the provision of assisted living service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage assisted living. Separate payment is not made for ADvantage respite to a member while receiving assisted living services since by definition assisted living services assume the responsibility for twenty-four (24) hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage assisted living services provider is allowed to charge a maximum for room and board that is no more than ninety (90) percent of the Supplemental Security Income (SSI) Federal Benefit Rate. When, per Oklahoma Administrative Code (OAC) 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

(8) The maximum total annual reimbursement for a member's hospice care within a twelve (12) month period is limited to an amount equivalent to eighty-five (85) percent of the Medicare Hospice Cap payment.

(b) The ~~OKDHS AS~~OHS CAP approved ADvantage person-centered service plan is the basis for the Medicaid Management Information Systems (MMIS) service prior authorization, specifying the:

(1) Service;

(2) Service provider;

(3) Units authorized; and

(4) Begin and end dates of service authorization.

(c) Service time for personal care, case management services, home health care, nursing, skilled nursing, supportive/restorative assistance, and in-home respite, is documented through the use of the designated statewide Electronic Visit Verification System (EVV) when services are

provided in the home. Providers are required to use the EVV system after access to the system is made available by ~~OKDHS~~OHS. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability.
(d) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims not supported by service plan authorization and documentation of service provisions are given to OHCA's Program Integrity Unit for follow-up investigation.

## PART 95. AGENCY PERSONAL CARE SERVICES

### 317:30-5-950. Eligible providers

Reimbursement for personal care services (PCS) and home health care services (HHCS) is made only to agencies that are certified as home care agency providers by the Oklahoma State Department of Health and are certified by the ADvantage Administration as meeting applicable federal, state and local laws, rules and regulations. In order to be eligible for reimbursement, the home care agency must have an approved provider agreement on file with the Oklahoma Health Care Authority, per Oklahoma Administrative Code (OAC) 317:30-3-2. Service time of ~~personal care~~PCS and HHCS is documented through the designated statewide Electronic Visit Verification (EVV) system when services are provided in the member's home. The home care agency is required to use the EVV system. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability. Refer to OAC 317:35-17-22 for additional instructions.

### 317:30-5-953. Billing

A billing unit for personal care services (PCS) and home health care services (HHCS) provided by a home care agency is fifteen (15) minutes of service delivery and equals a visit. Billing procedures for ~~personal care services~~PCS and HHCS are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Service time for ~~personal care and nursing~~PCS and HHCS is documented through the designated statewide Electronic Visit Verification (EVV) system. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability.

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

## SUBCHAPTER 15. STATE PLAN PERSONAL CARE SERVICES

### 317:35-15-8.1. Agency State Plan Personal Care services; billing, and problem resolution

The ADvantage Administration (AA) certifies qualified personal care provider agencies and facilitates the execution of the agencies' SoonerCare (Medicaid) contracts on the Oklahoma Health Care Authority's (OHCA`) behalf. OHCA checks the list of providers barred from Medicare/SoonerCare (Medicaid) participation to ensure that the personal care services agency is not listed.

(1) **Payment for State Plan Personal Care (SPPC).** Payment for SPPC services is made for care provided in the member's own home or in other limited living arrangement types, per Oklahoma Administrative Code (OAC) 317:35-15-2(c) (1 through 5).

(A) **Provider agency use.** To provide SPPC services, an agency must be licensed by the Oklahoma State Department of Health, meets certification standards identified by Oklahoma Human Services ~~(OKDHS)~~(OHS), and possesses a current SoonerCare (Medicaid) contract.

(B) **Reimbursement.** SPPC services payment on a member's behalf is made according to the service type and number of authorized service units.

(i) The amount paid to provider agencies for each service unit is determined according to established SoonerCare (Medicaid) rates for the personal care services. Only authorized units contained in each eligible member's individual plan are eligible for reimbursement. Provider agencies serving more than one member residing in the same residence ensure the members' plans combine units in the most efficient manner to meet the needs of all eligible persons in the residence.

(ii) SPPC services payment is for tasks performed in accordance with the authorized care plan per OAC 317:30-5-951. Payment for personal care and skilled nursing service is made on the member's behalf for assessment, evaluation, and associated service planning per nursing visit.

(iii) SPPC service time is documented through the Electronic Visit Verification System (EVV), previously known as Interactive Voice Response Authentication (IVRA) system, when services are provided in the home.

(2) **Issue resolution.**

(A) The provider agency provides a written copy of their grievance process to each member at service commencement. The written grievance process includes the name and phone number of a provider agency contact person who is responsible for responding to such complaints and grievances. When the member is dissatisfied with the SPPC provider agency or the assigned PCA and has exhausted attempts to work with the agency's grievance process without resolution, the member is referred to the OHS~~OKDHS~~ State Plan Care Unit to attempt to resolve the issue(s). The member has the right to appeal to OHCA per OAC 317:2-1-2.

(B) When a PCA performance issue is identified, provider agency staff conducts a counseling conference with the member or the PCA as appropriate. Provider agency staff counsels the PCA regarding problems with his or her performance.

(3) **Persons ineligible to serve as a PCA.** Payment from SoonerCare funds for SPPC services may not be made to an individual who is a legally responsible family member of the member, such as a spouse, legal guardian, or parent of a minor child, when he or she is providing SPPC services.

**317:35-15-14. Billing procedures for State Plan personal care**

Billing procedures for State Plan Personal Care (SPPC) services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through studying the manual are referred to the Oklahoma Health Care Authority (OHCA). SPPC contractors bill on CMS-1500 claim form. ~~OHCA provides instructions to a contracted Individual Personal Care Assistant (IPCA) for claim completion at the contractor's orientation.~~ The contracted provider submits a claim for each member. The contracted provider prepares claims for services provided and submits the claims to the fiscal agent responsible for ensuring claims are properly completed. All personal care contractors must have a unique provider number. New contracted providers are mailed the provider number after being placed on the claims processing contractor's provider file. All services provided in the member's home, including Personal Care and Nursing, and all work completed in the provider's office, are documented through the Electronic Visit Verification (EVV) system. The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of an EVV system failure, the provider documents time in accordance with internal provider agency policy and procedures backup plan. This documentation is sufficient to account for both in-home and in-office services. The provider agency's backup procedures are only permitted when the EVV system is unavailable.

## SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

**317:35-17-22. Billing procedures for ADvantage services**

(a) Billing procedures for long-term care medical services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the Oklahoma Health Care Authority (OHCA).

(b) The Oklahoma ~~Department of~~ Human Services ~~OKDHS Aging Services (AS)~~(OHS) Community, Aging and Protective Services (CAP) approved ADvantage service plan is the basis for the Medicaid Management Information Systems service prior authorization, specifying the:

(1) Service;

(2) Service provider;

(3) Units authorized; and

(4) Begin- and end-dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits are used to evaluate if paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims not supported by service plan authorization and/or documentation of service provision are turned over to the OHCA Clinical Provider Audits Unit for follow-up investigation.

(d) All contracted providers for ADvantage Waiver services must submit billing to the OHCA, ~~Soonercare~~SoonerCare using the appropriate designated software, or web-based solution for all

claims transactions. When the designated system is unavailable, contracted providers submit billing directly to OHCA.

(e) Service time of personal care, case management, home health care, nursing, advanced supportive/restorative assistance, in-home respite, consumer-directed personal assistance services and supports, personal services assistance, and advanced personal services assistance is documented through the designated statewide Electronic Visit Verification System (EVV) when provided in the home. Providers are required to use the EVV system. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability.

(f) The provider must document the amount of time spent for each service, per Oklahoma Administrative Code (OAC) 317:30-5-763. For service codes that specify a time segment in their description, such as fifteen (15) minutes, each timed segment equals one (1) unit. Only time spent fulfilling the service for which the provider is authorized, per OAC 317:30-5-763 is authorized for time-based services. Providers do not bill for a unit of time when not more than one-half of a timed unit is performed, such as, when a unit is defined as fifteen (15) minutes, providers do not bill for services performed for less than eight (8) minutes. The rounding rules utilized by the EVV and web-based billing system to calculate the billable unit-amount of care, services provided for duration of:

(1) Less than eight (8) minutes cannot be rounded up and do not constitute a billable fifteen (15) minute unit; and

(2) Eight (8) to fifteen (15) minutes are rounded up and do constitute a billable fifteen (15) minute unit.

# TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
# CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
# SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

**317:30-5-241.4 Crisis Intervention**

(a) **Onsite and Mobile Crisis Intervention Services (CIS)**.

(1) **Definition**. CIS are face-to-face services for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or danger of AOD relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented.

(A) Onsite CIS is the provision of CIS to the member at the treatment facility, either in-person or via telehealth.

(B) Mobile CIS is the provision of CIS by at least one (1) professional at the location of a member who is not at the treatment facility (e.g., services provided at the member's home).

(2) **Limitations**. CIS are not compensable for SoonerCare members who reside in ICF/IID facilities, or who receive RBMS in a group home or therapeutic foster home. ~~CIS is also not compensable for members who experience acute behavioral or emotional dysfunction while in attendance for other behavioral health services, unless there is a documented attempt of placement in a higher level of care. The maximum is eight (8) units per month; established mobile crisis response teams can bill a maximum of four (4) hours per month, and ten (10) hours each twelve (12) months per member.~~ Mobile CIS may not be separately billed while a member is receiving services within another behavioral health setting which are reimbursed on a per diem basis when the per diem rate is inclusive of mental health crisis or stabilization services (e.g., partial hospitalization program). There are no limitations on the hours of services that eligible members can receive.

(3) **Qualified professionals**. Services must be provided by an LBHP or licensure candidate.

(b) **Facility Based Crisis Stabilization (FBCS).** FBCS services are emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment.

(1) **Qualified practitioners**. FBCS services are provided under the supervision of a physician aided by a licensed nurse, and also include LBHPs and licensure candidates for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system.

(2) **Limitations**. The unit of service is per hour. Providers of this service must meet the requirements delineated in the OAC 450:23. Documentation of records must comply with OAC 317:30-5-248.

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 6. INPATIENT PSYCHIATRIC HOSPITALS

**317:30-5-95.1. Medical necessity criteria and coverage for adults aged twenty-one (21) to sixty-four (64)**

(a) **Coverage for adults**. Coverage for adults aged twenty-one (21) to sixty-four (64) is limited to services in a psychiatric unit of a general hospital or in a psychiatric hospital (see OAC 317:30-5-95). Inpatient psychiatric services must be prior authorized in accordance with OAC 317:30-5-41.1. OHCA rules that apply to inpatient psychiatric coverage for adults aged twenty-one (21) to sixty-four (64) are found in Sections OAC 317:30-5-95.1 through 317:30-5-95.10.

(b) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for psychiatric disorders**. An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) that is attributable to a psychiatric disorder must meet the terms or conditions contained in (1), (2), (3), (4), one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) A primary presenting diagnosis from the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM) ~~with the exception of~~that is consistent with the primary reason for admission. Diagnoses such as Autism Spectrum Disorder (ASD), Intellectual Disability (ID), V-codes, adjustment disorders, and substance related disorders ~~accompanied by a detailed description of the symptoms supporting the diagnosis~~ may be included as a secondary diagnosis. A diagnosis of ASD or ID cannot be exclusionary and may be present and documented as coexisting with other qualifying conditions for admission.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses). ~~Adjustment or substance related disorder may be a secondary diagnosis.~~

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a less intensive treatment program.

(4) Adult must be medically stable.

(5) Within the past forty-eight (48) hours, the behaviors present an imminent life-threatening emergency such as evidenced by:

(A) Specifically described suicide attempts, suicidal intent, or serious threat by the patient.

(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

(6) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

(C) Physiological evidence or expectation of withdrawal symptoms which require

twenty-four (24) hour medical supervision.

(c) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for inpatient chemical dependency detoxification/withdrawal management.** An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) for chemical dependency/ substance use/ detoxification must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.

(1) Any psychoactive substance dependency disorder described in the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses).

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a less intensive treatment program.

(4) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Need for active and aggressive pharmacological interventions.

(B) Need for stabilization of acute psychiatric symptoms.

(C) Need extensive treatment under physician direction.

(D) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

**317:30-5-95.25. Medical necessity criteria for acute psychiatric admissions for children**

Acute psychiatric admissions for children must meet the terms or conditions contained in (1), (2), (3), (4) and one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) A primary presenting diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) ~~with the exception of~~that is consistent with the primary reason for admission. Diagnoses such as Autism Spectrum Disorder (ASD), Intellectual Disability (ID), V-codes, adjustment disorders, and substance related disorders, ~~accompanied by a detailed description of the symptoms supporting the diagnosis~~may be included as a secondary diagnosis. In lieu of a qualifying diagnosis, children 18-21 years of age may have a diagnosis of any personality disorder. A diagnosis of ASD or ID cannot be exclusionary and may be present and documented as coexisting with other qualifying conditions for admission.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). ~~Adjustment or substance related disorder may be a secondary diagnosis.~~

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.

(4) Child must be medically stable.

(5) Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:

(A) Specifically described suicide attempts, suicide intent, or serious threat by the patient.

(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(C) Specifically described episodes of unprovoked significant physical aggression and

patterns of escalating physical aggression in intensity and duration.

(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

(6) Requires secure 24-hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 6. INPATIENT PSYCHIATRIC HOSPITALS

### 317:30-5-95.43. Residential substance use disorder treatment

(a) **Purpose**. The purpose of sections OAC 317:30-5-95.43 - 317:30-5-95.49 is to establish the procedures and requirements for residential treatment facilities providing SUD treatment services.
(b) **Definitions**. The following words and terms, when used in the aforementioned sections, shall have the following meanings unless the context clearly indicates otherwise.

(1) **"ASAM"** means the American Society of Addiction Medicine.

(2) **"ASAM criteria"** means the most recent edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

(3) **"ASAM levels of care"** means the different options for treatment as described below and in the current edition of the ASAM criteria that vary according to the intensity of the services offered. Each treatment option is a level of care.

(A) **"ASAM level 3"** means residential and inpatient services and encompasses ASAM levels 3.1, 3.3, 3.5 and 3.7.

(B) **"ASAM level 3.1"** means clinically managed low-intensity residential services for adolescents and adults. This level of care typically provides at least five (5) hours of clinical services a week and provides a twenty-four (24) hour living support and structure with trained personnel. The corresponding service description for this level of care is halfway house services.

(C) **"ASAM level 3.3"** means clinically managed population-specific high-intensity residential services. This level of care is for adults only and typically offers twenty-four (24) hour care with trained personnel and is designed to accommodate individuals with cognitive or other impairments. The corresponding service description for this level of care is residential treatment for adults with co-occurring disorders.

(D) **"ASAM level 3.5"** means clinically managed medium-intensity residential services for adolescents and clinically managed high-intensity residential services for adults. This level of care provides twenty-four (24) hour care and offers a wide range of therapeutic services. The corresponding service descriptions for this level of care are residential treatment and intensive residential treatment.

(E) **"ASAM level 3.7"** means medically monitored high-intensity inpatient services for adolescents and medically monitored intensive inpatient withdrawal management for adults. This level of care ~~provides twenty-four (24) hour nursing care with physician supervision and medication availability~~is provided by a licensed independent practitioner [physician, Advanced Practice Registered Nurse (APRN), or physician assistant (PA)] either on-site or on-call with twenty-four (24) hour care by a Registered Nurse (RN) on-site for supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this level of care is medically supervised withdrawal management.

(4) **"Care management services"** means an assessment of a member, development of a care plan, and referral and linkage to SUD community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.
(5) **"Co-occurring disorder (COD)"** means any combination of mental health symptoms and SUD symptoms or diagnoses that affect a member and are typically determined by the Diagnostic and Statistical Manual of Mental Disorders (DSM).
(6) **"DSM"** means the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
(7) "**ODMHSAS**" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
(8) **"Per diem"** means an all-inclusive rate for covered SUD treatment services provided each day during a facility stay.
(9) **"Rehabilitation services"** means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. Rehabilitation services for substance use disorders are also referred to as skill development services.
(10) "**Service plan**" means the document used during the process by which an LBHP or a licensure candidate and the member together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.
(11) "**Substance use disorder (SUD)"** means alcohol or drug dependence, or psychoactive SUD as defined by the most recent DSM criteria.
(12) "**Therapeutic services"** means professional services during which members engage in identifying, addressing and/or resolving issues identified in the member's service plan.
(13) **"Treatment hours - residential"** means the structured hours in which a member is involved in receiving professional services to assist in achieving recovery.

**317:30-5-95.46. Residential substance use disorder (SUD) - Covered services and medical necessity criteria**

(a) In order for the services described in this Section to be covered, individuals shall:
(1) Be diagnosed with an SUD as described in the most recent edition of the DSM; and
(2) Meet residential level of care as determined through completion of the designated ASAM placement tool as required by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
(3) For additional medical necessity criteria, refer to the ODMHSAS Prior Authorization Manual available at http://www.odmhsas.org/arc.htm.

(b) Coverage includes the following services:
(1) **Clinically managed low intensity residential services (ASAM Level 3.1).**
(A) **Halfway house services - Individuals age thirteen (13) to seventeen (17).**
(i) **Service description.** This service places a major emphasis on continuing SUD care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and for members age sixteen (16) and older, community recovery

support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided. A week begins on Sunday and ends on Saturday.

(B) **Halfway house services - Individuals age eighteen (18) to sixty-four (64).**

(i) **Service description.** This service places a major emphasis on continuing SUD care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided. A week begins on Sunday and ends on Saturday.

(C) **Halfway house services - Individuals with minor dependent children or women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven (7) days a week, supervised living arrangements, to include professionally directed evaluation, care, and treatment. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children**. Services are available to the child when provided to address the impacts related to the parent's addiction, including, but

not limited to, individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided to the individual with minor dependent children and women who are pregnant. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(2) **Clinically managed, population specific, high intensity residential services (ASAM Level 3.3).** This service includes residential treatment for adults with co-occurring disorders.

(A) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven / (7) days a week, structured evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of the member. Services include individual, family, and group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Psychiatric and/or psychological and/or mental health evaluations shall be completed on all members. In addition to the requirements in OAC 317:30-5-95.47, the service plan shall address the member's mental health needs and medications. The member's medications shall be re-assessed a minimum of once every thirty (30) days and monitoring of medications shall be provided. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider. Treatment services must address both mental health and SUD needs as identified in the service plan.

(B) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(C) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of individual, group, or family therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A week begins on Sunday and ends on Saturday. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours.

(3) **Clinically managed medium and high intensity (ASAM Level 3.5).**

(A) **Residential treatment, medium intensity - individuals age thirteen (13) to seventeen (17).**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. A multidisciplinary team approach shall be utilized in providing daily treatment services to assess and address the individual needs of each member, including individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and, for members age sixteen (16) or older, community recovery support services. Group therapy is limited to a total of

six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of fifteen (15) treatment hours for members attending academic training and twenty-four (24) treatment hours for members not attending academic training shall be provided. Weekly treatment hours shall include a minimum of one (1) hour of individual, family and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(B) **Residential treatment, high intensity - adults.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(C) **Intensive residential treatment, high intensity - adults.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone

twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(D) **Intensive residential treatment, high intensity - individuals age thirteen (13) to seventeen (17).**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or therapy, individual and/or group rehabilitation services, crisis intervention, care management, and, for members age sixteen (16) or older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of individual, family, or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(E) **Residential treatment for individuals with minor dependent children and women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide SUD treatment services to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site

twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children**. Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of twenty-four (24) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of one (1) hour of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(F) **Intensive residential treatment for individuals with dependent children and women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide SUD treatment services to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children**. Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A weekly minimum of thirty-five (35) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of four (4) hours of individual,

family, and/or group therapy and a minimum of seven (7) hours of individual and/or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(4) **Medically monitored high intensity withdrawal management (ASAM Level 3.7).**

(A) **Medically supervised withdrawal management - individuals age thirteen (13) to seventeen (17).**

(i) **Service description and requirements.** ~~This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs.~~ This level of care is provided by a licensed independent practitioner [physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)] either on-site or on-call with twenty-four (24) hour care by a Registered Nurse (RN) on-site for supervision and medication availability for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications shall be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** ~~A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week.~~ A licensed independent practitioner [physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)] must be available on-site or on-call and a Registered Nurse (RN) must be available on-site providing supervision of withdrawal management twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication. A minimum of two (2) medical and/or clinical/direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2.

(B) **Medically supervised withdrawal management - adults.**

(i) **Service description and requirements.** ~~This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs.~~ This level of care is provided by a licensed independent practitioner [physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)] either on-site or on-call with twenty-four (24) hour care by a Registered Nurse (RN) on-site for supervision and medication availability for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require

hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications shall be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** ~~A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week.~~ A licensed independent practitioner [physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)] must be available on-site or on-call and a Registered Nurse (RN) must be available on-site providing supervision of withdrawal management twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication.

**317:30-5-95.47. Residential substance use disorder (SUD) - Individualized service plan requirements**

All SUD services provided in residential treatment facilities are rendered as a result of an individual assessment of the member's needs and documented in the service plan.

(1) **Assessment.** A biopsychosocial assessment shall be completed for members receiving ASAM Level 3.1, 3.3, or 3.5 services, including dependent children receiving services from the residential SUD provider, to gather sufficient information to assist the member in developing an individualized service plan. The assessment must also list a diagnosis that corresponds to current Diagnostic and Statistical Manual of Mental Disorders (DSM) standards and the member's past and current psychiatric medications. The assessment must be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Assessments for ASAM Level 3.7 services shall be completed in accordance with (E) below.

(A) **Assessments for adolescents.** A biopsychosocial assessment ~~using the Teen Addiction Severity Index (T-ASI) shall be completed~~shall be completed utilizing an assessment tool approved by ODMHSAS. A physical examination shall be conducted by a licensed physician to include, at a minimum, a physical assessment, health history, immunization status, and evaluation of motor development and function, speech, hearing, visual, and language functioning.

(B) **Assessments for adults**. A biopsychosocial assessment using the Addiction Severity Index (ASI) shall be completed.

(C) **Assessments for dependent children.** Assessment of children (including infants) accompanying their parent into treatment and receiving services from the residential SUD provider shall include the following items:

(i) Parent-child relationship;

(ii) Physical and psychological development;

(iii) Educational needs;

(iv) Parent related issues; and

(v) Family issues related to the child.

(D) **Assessments for parents/pregnant women.** Assessment of the parent and/or pregnant women bringing their children into treatment shall include the following items:

(i) Parenting skills;

(ii) Knowledge of age appropriate behaviors;

(iii) Parental coping skills;

(iv) Personal issues related to parenting; and

(v) Family issues as related to the child.

(E) **Assessments for medically supervised withdrawal management**. In accordance with OAC 450:18-13-61, a medical assessment for the appropriateness of placement shall be completed and documented by a licensed ~~physician~~ independent practitioner [physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)] during the admission process. A Registered Nurse (RN) may assist with the assessment. RN signatures must be co-signed by a licensed physician, APRN or PA at the time the assessment is completed and must include a dated signature(s) of each practitioner. All assessments shall be signed by a licensed physician within 24 hours of admission, with the physician as the admitting practitioner of record. The assessment shall provide a diagnosis that corresponds to current DSM standards.

(F) **Assessment timeframes.** Biopsychosocial assessments shall be completed within ~~two (2) days~~forty-eight (48) hours of admission or ~~during the admission process~~within twenty-four (24) hours of admission for medically supervised withdrawal management.

(2) **Service plan.** Pursuant to OAC 450:18-7-81, a service plan shall be completed for each member receiving ASAM Level 3.1, 3.3, or 3.5 services, including dependent children receiving services from the residential SUD provider. The service plan is performed with the active participation of the member and a support person or advocate, if requested by the member. In the case of children under the age of sixteen (16), it is performed with the participation of the parent or guardian, if allowed by law, and the child as age and developmentally appropriate. Service plans for ASAM Level 3.7 services shall be developed in accordance with (D) below.

(A) **Service plan development**. The service plan shall:

(i) Be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(ii) Provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon member's progress or preference or the identification of new needs, challenges, and problems.

(iii) Be developed after and based on information obtained in the assessment and includes the evaluation of the assessment information by the clinician and the member.

(iv) Have an overall general focus on recovery which, for adults, may include goals like employment, independent living, volunteer work, or training, and for children, may include areas like school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(B) **Service plan content**. Service plans must include dated signatures for the member [if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. If the member is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Signatures must be obtained after

the service plan is completed. The contents of a service plan shall address the following:

(i) Member strengths, needs, abilities, and preferences;

(ii) Identified presenting challenges, needs, and diagnosis;

(iii) Goals for treatment with specific, measurable, attainable, realistic, and time-limited objectives;

(iv) Type and frequency of services to be provided;

(v) Description of member's involvement in, and response to, the service plan;

(vi) The service provider who will be rendering the services identified in the service plan; and

(vii) Discharge criteria that are individualized for each member and beyond that which may be stated in the ASAM criteria.

(C) **Service plan updates.** Service plan updates shall occur a minimum of once every thirty (30) days while services are provided. Service plan updates must include dated signatures for the member [if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. If the member is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Signatures must be obtained after the service plan is completed. Service plan updates shall address the following:

(i) Progress on previous service plan goals and/or objectives;

(ii) A statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(iii) Change in goals and/or objectives based upon member's progress or identification of new needs and challenges;

(iv) Change in frequency and/or type of services provided;

(v) Change in staff who will be responsible for providing services on the plan; and

(vi) Change in discharge criteria.

(D) **Service plans for medically supervised withdrawal management.** Pursuant to OAC 450:18-7-84, a service plan shall be completed for each member receiving ASAM Level 3.7 services that addresses the medical stabilization treatment and services needs of the member. Service plans shall be completed by a licensed ~~physician or licensed registered nursing staff and~~ independent practitioner [physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)], or Registered Nurse (RN). A Licensed Practical Nurse (LPN) may assist with the service plan. LPN signatures must be co-signed by a physician, APRN, PA, or RN at the time the service is completed. All service plans must include a dated signature of the member [if age fourteen (14) or older], the parent/guardian (if required by law), and the primary service practitioner. The service plan shall provide a diagnosis that corresponds to current DSM standards.

(E) **Service plan timeframes**. Service plans shall be completed within four (4) days of admission, except for service plans for individuals receiving medically supervised withdrawal management services, which must be completed within three (3) hours of admission.

(3) **Progress notes.** Progress notes shall chronologically describe the services provided, the member's response to the services provided, and the member's progress in treatment.

(A) **Content.** Progress notes shall address the following:

(i) Date;

(ii) Member's name;
(iii) Start and stop time for each timed treatment session or service;
(iv) Dated signature of the service provider;
(v) Credentials of the service provider;
(vi) Specific service plan needs, goals and/or objectives addressed;
(vii) Services provided to address needs, goals, and/or objectives;
(vii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
(ix) Member (and family, when applicable) response to the session or service provided; ~~and~~
(x) Any new needs, goals and/or objectives identified during the session or service~~.~~; and
(xi) Census for therapy and rehabilitation groups.

(B) **Frequency.** Progress notes shall be completed in accordance with the following timeframes:

(i) Progress notes for therapy, crisis intervention and care management must be documented in an individual note and reflect the content of each session provided.
(ii) Documentation for rehabilitation and community recovery support services must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), content of each service provided, and a daily progress note or a summary progress note weekly.

(4) **Transition~~/discharge~~ planning, assessment and discharge summary.** ~~All facilities shall assess each member for appropriateness of discharge from a treatment program. Each member shall be assessed using the ASAM placement tool to determine a clinically appropriate setting in the least restrictive level of care.~~ Transition/discharge plans shall be developed with the knowledge and cooperation of the member.

(A) **Transition/discharge plannings.** ~~Transition/discharge plans shall be developed with the knowledge and cooperation of the member. The transition/discharge plan shall be included in the discharge summary.~~ Development of the transition/discharge plan shall begin no later than two (2) weeks after admission. The discharge plan is to include, at a minimum, recommendations for continued treatment services and other appropriate community resources. Appointments for outpatient therapy and other services, as applicable, should be scheduled prior to discharge from residential care. ~~Development of the transition/discharge plan shall begin no later than two (2) weeks after admission.~~ The transition/discharge planning shall be included in the discharge summary.

(B) **Discharge Assessment.** All facilities shall assess each member for appropriateness of discharge from a treatment program. Each member shall be assessed using the ASAM placement tool to determine a clinically appropriate setting in the least restrictive level of care.

~~(B)~~(C) **Discharge summary.** The discharge summary shall document the member's progress made in treatment and response to services rendered. A completed discharge summary shall be entered in each member's record within fifteen (15) days of the member completing, transferring, or discontinuing services. The summary must be signed and dated by the staff member completing the summary.

**317:30-5-95.52. Documentation of records for adults receiving inpatient services**

~~(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Services documentation must include, at a minimum, the following:~~

~~(1) Date;~~
~~(2) Start and stop time for each session;~~
~~(3) Dated signature of the therapist and/or staff that provided the service;~~
~~(4) Credentials of the therapist;~~
~~(5) Specific problem(s) addressed (problems must be identified on the plan of care);~~
~~(6) Method(s) used to address problems;~~
~~(7) Progress made towards goals;~~
~~(8) Member's response to the session or intervention; and~~
~~(9) Any new problem(s) identified during the session.~~

~~(b) Signatures of the member, legal guardian (if applicable), physician, LBHP, and registered nurse (RN) are required on the individual plan of care (IPC) and all plan of care reviews. The IPC and plan of care review are not valid until signed and separately dated by the member, legal guardian (if applicable), physician, RN, LBHP, and all other requirements are met. All treatment team staff providing therapy services must sign the IPC and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.~~

(a) The service plan and service plan reviews are not valid until signed and separately dated by the member, legal guardian (if applicable), and LBHP or for medically supervised withdrawal management level of care, physician, APRN, PA, or RN, and all other requirements are met. All service plan and service plan reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing service plan and/or service plan reviews at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

~~(c)~~(b) Candidates for licensure for licensed professional counselor, social work (clinical specialty only), licensed marital and family therapist, licensed behavioral practitioner, licensed alcohol and drug counselor, and psychology (mental health specialty only) can provide assessments, psychosocial evaluations, individual therapy, family therapy, and process group therapy as long as they are involved in supervision that complies with their respective, approved licensing regulations and licensing boards. Additionally, their work must be co-signed and dated by a fully-licensed LBHP in good standing, who is a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed in one (1) of the areas of practice in OAC 317:30-5-240.3(a)(2) must have their work co-signed by a fully-licensed LBHP in good standing, who is a member on the treatment team. All co-signatures by fully-licensed LBHPs in good standing, must be accompanied by the date that the co-signature was made. Documentation of the service is not considered complete until it is signed and dated by a fully-licensed LBHP in good standing.

# 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

### 317:30-5-130. Inspections of care in Intermediate Care Facilities for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities (ICF/~~MR~~IID)

The Oklahoma Health Care Authority (OHCA) is responsible for periodic inspections of care and services in each ICF/~~MR~~IID providing services for Title XIX applicants and recipients. The inspection of care reviews are made by the OHCA or its designated agent. The frequency of inspections is based on the quality of care and service being provided in a facility and the condition of recipients in the facility. However, the care and services provided to each recipient in the facility must be inspected at least annually. No notification of the time of the inspection will be given to the facility prior to the inspections.

(1) The purpose of periodic inspections is to determine:

(A) The level of care required by each patient for whom Title XIX benefits have been requested or approved.

(B) The adequacy of the services available in the particular facility to meet the current health, rehabilitative and social needs of each recipient in an ICF/~~MR~~IID and promote the maximum physical, mental, and psychosocial functioning of the recipient receiving care in such facility.

(C) The necessity and desirability of the continued placement of each patient in such facility.

(D) The feasibility of meeting the health care needs and the recipient's rehabilitative needs through alternative institutional or noninstitutional services.

(E) If each recipient in an institution for the ~~mentally retarded~~intellectualy disabled or persons with related conditions is receiving active treatment.

(2) Each applicant and recipient record will be reviewed for the purpose of determining adequacy of services, unmet needs and appropriateness of placement. Personal contact with and observation of each recipient will occur during the visit. This may necessitate observing recipients at sites outside of the facility.

(A) Record reviews will include confirmation of whether:

(i) All required evaluations including medical, social and psychological are complete and current.

(ii) The habilitation plan is complete and current.

(iii) All ordered services are provided and properly recorded.

(iv) The attending physician reviews prescribed medications at least quarterly.

(v) Tests or observations of each recipient indicated by his medication regimen are made at appropriate times and properly recorded.

(vi) Physicians, nurse, and other professional progress notes are made as required and appear consistent with the observed condition of the recipient.

(vii) There is a habilitation plan to prevent regression and reflects progress toward meeting objectives of the plan.

(viii) All recipient needs are met by the facility or through arrangements with others.

(ix) The recipient needs continued placement in the facility or there is an appropriate

plan to transfer the recipient to an alternate method of care.

(B) Observations and personal contact with recipients will include confirmation of whether:

(i) The habilitation plans are followed.

(ii) All ordered services are provided.

(iii) The condition of the recipient is consistent with progress notes.

(iv) The recipient is clean and is receiving adequate hygiene services.

(v) The recipient is free of signs of malnutrition, dehydration and preventable injuries.

(vi) The recipient is receiving services to maintain maximum physical, mental, and psychosocial functioning.

(vii) The recipient needs any service that is not furnished by the facility or through arrangements with others.

(3) A full and complete report of observations, conclusions and recommendations are required concerning:

(A) The adequacy, appropriateness, and quality of all services provided in the facility or through other arrangements, including physician services to recipients; and

(B) Specific findings about individual recipients in the facility.

(4) The inspection report must include the dates of the inspection and the names and qualifications of the individuals conducting the inspection. A copy of each inspection report will be sent to:

(A) The facility inspected;

(B) The facility's utilization review committee;

(C) The agency responsible for licensing, certification, or approval of the facility for purposes of Medicare and Medicaid; and

(D) Other state agencies that use the information in the reports to perform their official function, including if inspection reports concern Institutions for Mental Diseases (IMDs), the appropriate State mental health authorities.

(5) The Oklahoma Health Care Authority will take corrective action as needed based on required reports and recommendations.

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

### 317:30-5-423. Coverage limitations

(a) Coverage limitations for residential supports for members with an intellectual disability are:

(1) Description: agency companion services (ACS); Unit: one day; Limitation: 366 units per year;

(2) Description: specialized foster care (SFC); Unit: one day; Limitation: 366 units per year;

(3) Description: daily living supports (DLS); Unit: one day; Limitation: 366 units per year; and

(4) Description: group home services; Unit: one day; Limitation: 366 units per year.

(b) Members may not receive ACS, SFC, DLS and group home services at the same time.

(c) Community transition services (CTS) are limited to $2,400 per eligible member.

(1) CTS is limited to one transition over the member's lifetime. If the member's situation changes after receipt of CTS and hospitalization or readmission to an intermediate care facility for the ~~mentally retarded~~intellectually disabled (ICF/~~MR~~IID) is necessary, CTS is not authorized upon transition back into the community.

(2) Members moving into a group home, SFC, or ACS arrangement in the companion's home are not eligible to receive CTS.

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

## SUBCHAPTER 5. ELGIBILITY AND COUNTABLE INCOME

## PART 3. NONMEDICAL ELIGIBILTY REQUIREMENTS

**317:35-5-26. Residence requirements; residents of public institutions; homeless persons; and residents of IHS, BIA or Tribal controlled dormitories**

(a) **Residence.** To be eligible for SoonerCare services, the applicant must be residing in the State of Oklahoma with intent to remain at the time the medical service is received. A durational residence requirement is not imposed.

(1) Temporary absence from the State, with subsequent returns to the State, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Oklahoma residence.

(2) Oklahoma residence does not include transients or visitors passing through the state but does not preclude persons who do not have a fixed address if intent is established.

(3) Intent to remain or return is defined as a clear statement of plans to remain or return in addition to other evidence and/or corroborative statements of others.

(4) When a non-resident makes application for SoonerCare benefits, the local office provides services necessary to make available to the applicant any SoonerCare services for which he/she might be eligible from his/her state of residence. The local office contacts the state or county of the applicant's residence to explore possible eligibility for medical benefits from the state and to obtain information needed for the determination of medical eligibility for the services received while in Oklahoma.

(5) If a member's whereabouts are unknown, as indicated by the return of unforwardable agency mail, refer to OAC 317:35-5-67.

(b) **Individuals residing in institutions (correctional facilities and institutions for mental disease).** The SoonerCare program will only pay for services rendered to adults (21 through 64 years of age) who are inpatients in an institution for mental disease (IMD), juveniles in the custody of the Office of Juvenile Affairs who are inmates in a state-owned and operated facility, or inmates in a correctional facility, when these individuals are admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility or an intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities and meet all other eligibility requirements.

(c) **Homeless individuals.** Individuals are not required to have a fixed address in order to be eligible for assistance. Individuals who lack a fixed or regular residence, who have temporary accommodations, i.e., supervised shelters, residence of other individuals, a hallway, bus station, car or other similar places, are considered as "homeless".

(d) **Individuals residing in IHS, BIA or Tribal controlled dormitories.** Individuals that reside in a facility which provides students boarding and lodging on a temporary residential basis for the purpose of attending a Bureau-operated or Indian-controlled contract or public school are considered Oklahoma residents for SoonerCare eligibility purposes.

## SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

## PART 1. SERVICES

**317:35-9-1. Overview of long-term medical care services; relationship to QMB, SLMB, and other Medicaid services eligibility, and spenddown calculation**

(a) **Long Term Medical Care Services**. Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities (refer to this subchapter), persons age 65 years or older in mental health hospitals (refer to this subchapter), Home and Community Based Waiver Services for the Intellectually Disabled (refer to this subchapter), and Home and Community Based Waiver Services for frail elderly and a targeted group of adults with physical disabilities age 21 and over who have not been determined to have a developmental disability, an intellectual disability or a related condition (refer to OAC 317:35-17). Personal Care provides services in the own home for categorically needy individuals (refer to OAC 317:35-15). Any time an individual is certified as eligible for Medicaid coverage of long-term care, the individual is also eligible for other Medicaid services. Another application or additional spenddown computation is not required. Spenddown is applied to the first long-term care claim filed. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required. Any spenddown computed for long-term care is not applicable to QMB or SLMB coverage.

(b) **Medicaid recovery.** The State of Oklahoma operates a Medicaid Recovery program to recover for services identified in OAC 317:35-9-15. Recovery can be accomplished in two ways: liens against real property or claims made against estates.

**317:35-9-5. Home and Community - Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions**

(a) Home and Community Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) per OAC 317:40-1-1. Oklahoma's Medicaid agency, the Oklahoma Health Care Authority (OHCA), provides oversight of Waiver operation. HCBS Waivers allow the OHCA to offer certain home and community based services to categorically needy members who, without such services, would be eligible for care in an Intermediate Care Facility for persons with ~~Mental Retardation~~an Intellectual Disability (ICF/~~MR~~IID).

(b) Members receiving HCBS Waiver services per OAC 317:40-1-1 are subject to HCBS Waiver service conditions (1)-(11) of this subsection. The rules in this subsection shall not be construed as a limitation of the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.

(1) HCBS Waiver services are subject to annual appropriations by the Oklahoma Legislature.

(2) DDSD must limit the utilization of the HCBS Waiver services based on:

(A) the federally-approved member capacity for the individual HCBS Waivers; and

(B) the cost effectiveness of the individual HCBS Waivers as determined according to federal requirements; and

(3) DDSD must limit enrollment when utilization of services under the HCBS Waiver programs is projected to exceed the spending authority.

(4) Members receiving Waiver services must have full access to State plan services for which they are eligible including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when children participate in a Waiver.
(5) A member's room and board expenses may not be paid through a Waiver. Room and board expenses must be met from member resources or through other sources.
(6) A member must require at least one Waiver service per month or monthly case management monitoring in order to function in the community.
(7) Waiver services required by a member must be documented in advance of service delivery in a written plan of care.
(8) Members exercise freedom of choice by choosing Waiver services instead of institutional services.
(9) Members have the right to freely select from among any willing and qualified provider of Waiver services.
(10) The average costs of providing Waiver and non-Waiver SoonerCare services must be no more costly than the average costs of furnishing institutional (and other SoonerCare state plan) services to persons who require the same level of care.
(11) Members approved for services provided in a specific Waiver must be afforded access to all necessary services offered in the specific Waiver if the member requires the service.

## PART 2. MEDICAID RECOVERY PROGRAM

**317:35-9-15. Medicaid recovery**

(a) **General overview.** The Omnibus Budget Reconciliation Act of 1993 mandates the State to seek recovery against the estate of certain Title XIX members who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received. The payment of Title XIX by the Oklahoma Health Care Authority (OHCA) on behalf of a member who is an inpatient of a nursing facility, intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities or other medical institution creates a debt to the OHCA subject to recovery by legal action either in the form of a lien filed against the real property of the member and/or a claim made against the estate of the member. Only Title XIX received on or after July 1, 1994, will be subject to provisions of this Part. Recovery for payments made under Title XIX for nursing care is limited by several factors, including the family composition at the time the lien is imposed and/or at the time of the member's death and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. [See OAC 317:35-5-41.8(a)(3)(H) for consideration of home property as a countable resource.] State Supplemental Payments are not considered when determining the countable income. The types of medical care for which recovery can be sought include:

(1) nursing facility services;
(2) home and community based services;
(3) related hospital services;
(4) prescription drug services;
(5) physician services; and
(6) transportation services.

(b) **Recovery through lien.** The Oklahoma Health Care Authority (OHCA) may file and enforce a lien, after notice and opportunity for a hearing, against the real property of a member who is an inpatient in a nursing facility, ICF/~~MR~~IID or other medical institution in certain instances.

(1) **Exceptions to filing a lien**.

(A) A lien may not be filed on the home property if the member's family includes:

(i) a surviving spouse residing in the home;

(ii) a child or children age 20 or less lawfully residing in the home ;

(iii) a disabled child or children of any age lawfully residing in the home; or

(iv) a brother or sister of the member who has an equity interest in the home and has been residing in the home for at least one year immediately prior to the member's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

(B) If an individual covered under an Oklahoma Long-term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual for the amount of assets or resources disregarded.

(2) **Reasonable expectation to return home**. A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return to the home. To return home means the member leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care. Hospitalizations of short duration that do not include convalescent care are not counted in the 90 day period. Upon certification for Title XIX for nursing care, OKDHS provides written notice to the member that a one-year period of inpatient care constitutes a determination by the OKDHS that there is no reasonable expectation that the member will be discharged and return home for a period of at least 90 days. The member or the member's representative is asked to declare intent to return home by signing the OKDHS Form 08MA024E, Acknowledgment of Intent to Return Home/Medicaid Recovery Program. Intent is defined here as a clear statement of plans in addition to other evidence and/or corroborative statements of others. Should the intent be to return home, the member must be informed that a one-year period of care at a nursing facility or facilities constitutes a determination that the member cannot reasonably be expected to be discharged and return home. When this determination has been made, the member receives a notice and opportunity for hearing. This notification occurs prior to filing of a lien. At the end of the 12-month period, a lien may be filed against the member's real property unless medical evidence is provided to support the feasibility of his/her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.

(3) **Undue hardship waiver**. When enforcing a lien or a recovery from an estate [see (c) of this Section] would create an undue hardship, a waiver may be granted. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that the individual's health or life would be endangered. Undue hardship exists when application of the rule would deprive the individual or family members who are financially dependent on him/her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, when the individual or his/her family is merely inconvenienced or when their lifestyle is restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section. Upon applying for an undue hardship waiver, an individual will receive written notice, in a timely process, whether an undue hardship waiver will be granted.

If an undue hardship waiver is not granted, the individual will receive written notice of the process under which an adverse determination can be appealed. The OHCA Legal Division staff will receive notification on all undue hardship waiver decisions.

(4) **Filing the lien**. After it has been determined that the member cannot reasonably be expected to be discharged from the nursing facility and return home and the member has been given notice of an intent to file a lien against the real property and an opportunity for a hearing on the matter, a lien is filed by the Oklahoma Health Care Authority, Third Party Liability Unit, for record against the legal description of the real property in the office of the county clerk of the county in which the property is located. A copy of the lien is sent by OHCA to the member or his/her representative. The lien must contain the following information:

(A) the name and mailing address of the member, spouse, legal guardian, authorized representative, or individual acting on behalf of the member;

(B) the amount of Title XIX paid at the time of the filing of the lien and a statement that the lien amount will continue to increase by any amounts paid thereafter for Title XIX on the member's behalf;

(C) the date the member began receiving compensated inpatient care at a nursing facility or nursing facilities, intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities or other medical institution;

(D) the legal description of the real property against which the lien will be recorded; and

(E) the address of the Oklahoma Health Care Authority.

(5) **Enforcing the lien**. The lien filed by OHCA for Title XIX correctly received may be enforced before or after the death of the member. But it may be enforced only:

(A) after the death of the surviving spouse of the member or until such time as the surviving spouse abandons the homestead to reside elsewhere;

(B) when there is no child of the member, natural or adopted, who is 20 years of age or less residing in the home;

(C) when there is no adult child of the member, natural or adopted, who is blind or disabled, as defined in OAC 317:35-1-2, residing in the home;

(D) when no brother or sister of the member is lawfully residing in the home, who has resided there for at least one year immediately before the date of the member's admission to the nursing facility, and has resided there on a continuous basis since that time; and

(E) when no son or daughter of the member is lawfully residing in the home who has resided there for at least two years immediately before the date of the member's admission to the nursing facility, and establishes to the satisfaction of the OKDHS that he or she provided care to the member which permitted the member to reside at home rather than in an institution and has resided there on continuous basis since that time.

(6) **Dissolving the lien**. The lien remains on the property even after transfer of title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The member or member's representative may discharge the lien at any time by paying the amount of lien to the OHCA. Should the payment of the debt secured by the lien be made to the county office, the payment is forwarded to OHCA/Third Party Liability, so that the lien can be released within 50 days. After that time, the member or the member's representative may request in writing that it be done. This request must describe the lien and the property with reasonable certainty. By statute, a fine may be levied against the lien holder if it is not released in a timely manner.

(B) The member leaves the nursing facility and resides in a property to which the lien is

attached, for a period of more than 90 days without being re-admitted to a facility providing nursing care, even though there may have been no reasonable expectation that this would occur. If the member is re-admitted to a nursing facility during this period, and does return to his/her home after being released, another 90 days must be completed before the lien can be dissolved.

(7) **Capital resources**. Rules on the determination of capital resources for individuals related to the aged, blind, or disabled (See OAC 317:35-5-41 through 317:35-5-41.7) apply to the proceeds received for the property in excess of the amount of the lien after the lien is satisfied.

(c) **Recovery from estates**.

(1) If the member was age 55 or older when the nursing care was received, adjustment or recovery may be made only after the death of the individual's spouse, if any, and at a time when there are no surviving children age 20 or less and no surviving disabled children of any age living in the home. Oklahoma Statutes contain stringent time frames concerning when and how claims against an estate in probate are filed and paid. Therefore, timely updating of computer input forms indicating the death of the member is crucial to insure the OHCA's ability to file timely against the estate.

(2) The estate consists of all real and personal property and other assets included in member's estate as defined by Title 58 of the Oklahoma Statutes. Although county staff ordinarily will not be responsible for inventorying or assessing the estate, assets and property that are not considered in determining eligibility should be documented in the case record.

(3) After updating of computer input form indicating member's death, a computer generated report is sent to OHCA/Third Party Liability (TPL). This report will serve as notification to OHCA/TPL to initiate estate recovery.

(4) Undue hardship waivers may be granted for estate recovery as provided in (b)(3) of the Section.

(5) If an individual covered under an Oklahoma Long-Term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual's estate for the amount of assets or resources disregarded.

## PART 3. APPLICATION PROCEDURES

**317:35-9-25. Application for ~~ICF/MR~~ICF/IID, HCBW/ID, and persons aged 65 or over in mental health hospitals.**

(a) **Application procedures for long-term medical care**. An application for these types of services consists of the Medical Assistance Application. The Medical Assistance Application is signed by the patient, parent, spouse, guardian or someone else acting on the patient's behalf.

(1) All conditions of eligibility must be verified and documented in the case record. When current information already available in the local office establishes eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(2) At the request of an individual in an ~~ICF/MR~~ICF/IID or receiving Home and Community Based Waiver Services for the Intellectually Disabled or the community spouse, if application for Medicaid is not being made, an assessment of the resources available to each spouse is made by use of DHS Form MA-11, Assessment of Assets. Documentation of resources must

be provided by the individual and/or spouse. This assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid eligibility is made. A copy of Form MA-11 is provided to each spouse for planning in regard to future eligibility. A copy is retained in the county office in case of subsequent application.

(3) If assessment by Form MA-11 was not done at the time of entry into the ~~ICF/MR~~ICF/IID or HCBW/ID services, assessment by use of Form MA-11 must be done at the time of application for Medicaid. The spousal share of resources is determined in either instance for the month of entry into the ~~ICF/MR~~ICF/IID or HCBW/ID services. If the individual applies for Medicaid at the time of entry into the ~~ICF/MR~~ICF/IID or HCBW/ID services, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the Medicaid application form and computed using DHS Form MA-12, Title XIX Worksheet.

(b) **Date of application**. When application is made in the county office the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application is stamped into the county office. When a request for Medicaid is first made by an oral request, and the application form is signed later, the date of the oral request is entered in "red" above the date the form is signed. The date of the oral request is the date of application.

**317:35-9-26. Application procedures for private ICF/~~MR~~IID**

Individuals may apply for private ~~ICF/MR~~ICF/IID at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active SoonerCare case. The OKDHS Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice form 08MA083E, when received in the HSC, also constitutes an application request and is handled the same as an oral request. The local HSC will send the ~~ICF/MR~~ICF/IID OKDHS form 08MA038E within three working days of receipt of OKDHS forms 08MA083E and 08MA084E, Management of Recipient's Funds, indicating actions that are needed or have been taken regarding the member.

**317:35-9-27. Application procedures for public ~~ICF/MR~~ICF/IID**

When an individual is admitted to a public ~~ICF/MR~~ICF/IID, an application for payment of long-term care in the facility is made at the time of admission. A designated worker from the county office in the county where the facility is located assists in this part of the admission process. The superintendent of the facility may sign the application on behalf of the individual if the responsible parent or guardian is not available. A case record is set up, in the county where the facility is located, for each applicant of the public ~~ICF/MR~~ICF/IID. If the individual leaves the facility, the county case is transferred, if necessary, to the county of residence

## PART 11. PAYMENT, BILLING, AND OTHER ADMINSTRATIVE PROCEDURES

**317:35-9-103. Special procedures for release of adults in mental health hospitals to long-term care facilities**

(a) **Procedures**. Adult patients in state mental health hospitals being considered for release to long-term care facilities due to their physical conditions may be predetermined eligible for Medicaid.

(b) **Responsibility of mental health hospitals**. The mental health hospital social and reimbursement staff works with the Social Security Administration to secure the approval for Supplemental Security Income (SSI) for individuals not currently eligible who may qualify for SSI. They will also assist the patient with the application for Medicaid medical services. By forwarding the completed Medical Assistance Application form and the Capital Resources Information form to the county office, the determination of financial eligibility by the DHS county worker can proceed at the same time that SSA is determining SSI eligibility. If the individual has other income (Social Security, VA, etc.) and does not qualify for SSI, the mental health hospital social and reimbursement staff evaluates the known resources. If the resources do not exceed the maximum as shown on the DHS Appendix C-1, Schedule VIII. D., individuals may be referred for a decision of eligibility for care in an intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities and, if necessary, categorical relationship. If the individual appears to meet the requirements as set out in this Subchapter, the mental health hospital social and reimbursement staff will submit a copy of the admitting history and physical progress notes, psychiatric examination and a physician's recommendation for a specific level of care, based on the individual's physical condition, to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division for review. If release to a long-term care facility appears appropriate, the medical information is submitted to LOCEU at the same time that the application forms are submitted to the county.

(c) **Responsibility of LOCEU**. The LOCEU reviews the hospital records, the social summary, the physician's recommendation for level of care as well as categorical relationship, if necessary. A Level II PASRR assessment is initiated by LOCEU at this point, if indicated. The MEDATS file is updated advising the DHS county office of LOCEU's decision.

(d) **Responsibility of the DHS county office**. The county office (in the county where the hospital is located) has the responsibility for the case number assignment, placing the case in application status and the subsequent determination of financial eligibility. The case is not certified until the patient enters an approved long-term care facility.

(1) Once the patient is determined financially and medically eligible a letter (including the assigned case number) is sent to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division.

(2) If the patient is determined to be ineligible, the denial is teleprocessed and a computer generated notice sent to the client or responsible person.

(e) **Release from mental health hospital to a long-term care facility**. After the hospital receives the letter from the county office with anticipated approval for Medicaid, the arrangements for release to the long-term care facility will proceed. The hospital will supply the long-term care facility with appropriate medical and social information and a copy of the DHS letter concerning the financial and medical eligibility.

(1) The long-term care facility, upon acceptance of the patient, forwards DHS form ABCDM-83, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice (with the assigned case number) to the DHS county office where the long-term care facility is located.

(2) If the long-term care facility is in a different county than the hospital, the county of the facility requests the transfer of the case record. The certification is teleprocessed prior to the transfer of the case record.

## SUBCHAPTER 19. NURSING FACILITY SERVICES

**317:35-19-6. Application procedures for NF**

Individuals may apply for nursing home care at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active SoonerCare case. For NF, OKDHS Form 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice form, when received in the HSC, also constitutes an application request and is handled the same as an oral request.

**317:35-19-9. PASRR screening process**

(a) **Level I screen for PASRR.**

(1) OHCA Form LTC-300R, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:

(A) The NF administrator or co-administrator;

(B) A licensed nurse, social service director, or social worker from the facility; or

(C) A licensed nurse, social service director, or social worker from the hospital.

(2) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form LTC-300R and the Minimum Data Set (MDS), if available, as well as all other readily available medical and social information, to determine if there currently exists any indication of mental illness (MI), intellectual disability (ID), or other related condition, or if such condition existed in the applicant's past history. Form LTC-300R constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II is necessary prior to allowing the member to be admitted.

(3) The NF is responsible for determining from the evaluation whether or not the member can be admitted to the facility. A "yes" response to any question from Form LTC-300R, Section E, will require the NF to contact the Level of Care Evaluation Unit (LOCEU) for a consultation to determine if a Level II assessment is needed. The facility is also responsible for consulting with the LOCEU regarding any mental illness, an intellectual disability, or related condition information that becomes known either from completion of the MDS or throughout the resident's stay. The original Form LTC-300R must be submitted to the LOCEU by mail within ten (10) days of the resident's admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

(4) Upon receipt and review of the PASRR eligibility information packet, the LOCEU may, in coordination with the Oklahoma Department of Human Services (OKHDS) area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II assessment is not required, as determined by the LOCEU, the area nurse, or nurse designee, documents this and continues with the process of determining medical eligibility. If a Level II is required, a medical decision is not made until the area nurse is notified of the outcome of the Level II assessment. The results of the Level II assessment are considered in the medical eligibility decision. The area nurse, or nurse designee, makes the medical eligibility decision within ten (10) working days of receipt of the medical information when a Level II assessment is not required. If a Level II assessment is required, the area nurse makes the decision within five working days if appropriate.

(b) **Pre-admission Level II assessment for PASRR.** The authorized official is responsible for consulting with the OHCA LOCEU in determining whether a Level II assessment is necessary. The decision for Level II assessment is made by the LOCEU.

(1) Any one of the following three (3) circumstances will allow a member to enter the NF without being subjected to a Level II PASRR assessment:

(A) The member has no current indication of mental illness or an intellectual disability or other related condition and there is no history of such condition in the member's past;

(B) The member does not have a diagnosis of an intellectual disability or related condition; or

(C) The member has indications of mental illness or an intellectual disability or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed only if all of the following three (3) conditions are met:

(i) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(ii) The individual must require NF services for the condition for which he/she received care in the hospital; and

(iii) The attending physician must certify before admission to the facility that the individual is likely to require less than thirty (30) days of nursing facility services. The NF will be required to furnish documentation to the OHCA upon request.

(2) If the member has current indications of mental illness or an intellectual disability or other related condition, or if there is a history of such condition in the member's past, the member cannot be admitted to the NF until the LOCEU is contacted to determine if a Level II PASRR assessment must be performed. Results of any Level II PASRR assessment ordered must indicate that NF care is appropriate prior to allowing the member to be admitted.

(3) The OHCA Level of Care Evaluation Unit authorizes Advance Group Determinations for the MI and ID Authorities in the categories listed in the following categories listed in (A) through (C) of this paragraph. Preliminary screening by the LOCEU should indicate eligibility for NF level of care prior to consideration of the provisional admission.

(A) **Provisional admission in cases of delirium.** Any person with mental illness, an intellectual disability or related condition who is not a danger to self and/or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(i) A Level II evaluation is completed immediately after the delirium clears. LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(ii) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(B) **Provisional admission in emergency situations.** Any person with a mental illness, an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified NF for a period not to exceed seven days pending

further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. LOCEU must be provided with written documentation from Adult Protective Services or the facility which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(C) **Respite care admission.** Any person with mental illness, an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified NF to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to fifteen (15) consecutive days per stay, not to exceed thirty (30) days per calendar year.

(i) In rare instances, such as illness of the caregiver, an exception may be granted to allow thirty (30) consecutive days of respite care. However, in no instance can respite care exceed thirty (30) days per calendar year.

(ii) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(c) **PASRR Level II resident review.** The resident review is used primarily as a follow-up to the pre-admission assessment.

(1) The facility's routine resident assessment will identify those individuals previously undiagnosed as intellectually disabled or mentally ill. A new condition of intellectual disabilities or mental illness must be referred to LOCEU by the NF for determination of the need for the Level II. The facility's failure to refer such individuals for a Level II assessment may result in recoupment of funds and/or penalties from CMS.

(2) A Level II resident review may be conducted the following year for each resident of a NF who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II to determine whether, because of the resident's physical and mental condition, the resident requires specialized services.

(3) A Level II resident review may be conducted for each resident of a NF who has mental illness or an intellectual disability or other related condition when there is a significant change in the resident's mental condition. If such a change should occur in a resident's condition, it is the responsibility of the facility to have a consultation with the LOCEU concerning the need to conduct a resident review.

(4) Individuals who were determined to have a serious mental illness on their last PASRR Level II evaluation will receive a resident review at least within one year of the previous evaluation.

(d) **Results of pre-admission Level II assessment and Resident Review.** Through contractual arrangements between the OHCA and the Mental Illness/Intellectual Disabilities Authorities/ Community Mental Health Centers, individualized assessments are conducted and findings presented in written evaluative reports. The reports recommend if NF services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or intellectual disability or related conditions. Evaluative reports are delivered to the OHCA's LOCEU within federal regulatory and state

contractual timelines to allow the LOCEU to process formal, written notification to member, guardian, NF and significant others.

(e) **Evaluation of pre-admission Level II or Resident Review assessment to determine Medicaid medical eligibility for long term care.** The determination of medical eligibility for care in a NF is made by the area nurse (or nurse designee) unless the individual has an intellectual disability or related condition or a serious mental illness. The procedures for obtaining and submitting information required for a decision are outlined in this subsection. When an active long term care member enters the facility and nursing care is being requested:

(1) The pre-admission screening process must be performed and must allow the member to be admitted.

(2) The facility will notify the local county office by the OKDHS Form 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice and Form 08MA084E, Management of Recipient's Funds, of the member's admission.

(3) The local county office will send the NF the OKDHS Form 08MA038E, Notice Regarding Financial Eligibility, indicating actions that are needed or have been taken regarding the member.

**317:35-19-31. Special procedures for release of adults in mental health hospitals to Nursing Facilities**

(a) **Procedures**. Adult patients in state mental health hospitals being considered for release to nursing facilities due to their physical conditions may be predetermined eligible for Medicaid.

(b) **Responsibility of mental hospitals**. The mental health hospital social and reimbursement staff works with the Social Security Administration to secure the approval for Supplemental Security Income (SSI) for individuals not currently eligible who may qualify for SSI. They will also assist the patient with the application for Medicaid medical services. By forwarding the completed Medical Assistance Application form and the Capital Resources Information form to the county office, the determination of financial eligibility by the DHS county social worker can proceed at the same time that SSA is determining SSI eligibility. If the individual has other income (Social Security, VA, etc.) and does not qualify for SSI, the mental health hospital social and reimbursement staff evaluates the known resources. If the resources do not exceed the maximum as shown on DHS Appendix C-1, Schedule VIII. D., individuals may be referred for a decision of eligibility for care in a nursing facility and, if necessary, categorical relationship. If the individual appears to meet the requirements as set out in this Subchapter, the mental health hospital social and reimbursement staff will submit a copy of the admitting history and physical progress notes, psychiatric examination and a physician's recommendation for a specific level of care, based on the individual's physical condition, to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division for review. If release to an NF appears appropriate, the medical information is submitted to LOCEU at the same time that the application forms are submitted to the county.

(c) **Responsibility of LOCEU.** The LOCEU reviews the hospital records, the social summary, the physician's recommendation for level of care as well as categorical relationship, if necessary. A Level II PASRR screen is initiated by LOCEU at this point, if indicated. The MEDATS file is updated advising the DHS county office of LOCEU decision.

(d) **Responsibility of county office**. The county office (in the county where the hospital is located) has the responsibility for the case number assignment, placing the case in application status and

the subsequent determination of financial eligibility. The case is not certified until the patient enters an approved nursing facility.

(1) Once the patient is determined financially and medically eligible a letter (including the assigned case number) is sent to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division.

(2) If the patient is determined to be ineligible, the denial is teleprocessed and a computer generated notice sent to the client or responsible person.

(e) **Release from mental health hospital to an NF**. After the hospital receives the letter from the county office with anticipated approval for Medicaid, the arrangements for release to the nursing facility will proceed. The hospital will supply the NF with appropriate medical and social information and a copy of the DHS letter concerning the financial and medical eligibility.

(1) The NF, upon acceptance of the patient, forwards the DHS form ABCDM-83, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice (with the assigned case number) to the DHS county office where the NF is located.

(2) If the NF is in a different county than the hospital, the county of the facility requests the transfer of the case record. The certification is teleprocessed prior to the transfer of the case record.

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 7. PHARMACIES

### 317:30-5-87. 340B Drug Discount Program

(a) The 340B Drug Discount Program is a drug-pricing program established under section 256b of Title 42 of the United States Code (U.S.C) under which a manufacturer of covered outpatient drugs agrees that it will not charge a 340B covered entity more than the 340B price for a 340B covered outpatient drug.

(b) Covered entities participating in the 340B Drug Discount Program will adhere to the following provisions outlined in this Section and as defined in 42 U.S.C. §256b. Covered entities must:

(1) Notify the OHCA Pharmacy Department in writing within thirty (30) days of any changes in 340B Program participation, as well as any changes in name, address, National Provider Identification (NPI), SoonerCare Provider Number, etc.

(2) Maintain their status on the Health Resources & Services Administration (HRSA) Medicaid Exclusion File (MEF) and report any changes to the OHCA within thirty (30) days.

(3) Execute a contract addendum with the OHCA in addition to their provider contract.

(4) Drugs designated by OHCA as 340B Carve Out Drugs shall be prohibited from being dispensed or administered to Oklahoma Medicaid members if purchased at 340B prices. Any drugs designated by OHCA as 340B Carve Out Drugs will be posted on the agency website at www.oklahoma.gov/ohca.

(c) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by covered entities when billed using the registered SoonerCare Provider Number on the MEF.

(1) All pharmacy claims submitted by covered entities shall be adjusted by the 340B ceiling price whether purchased through the 340B Program or otherwise.

(2) Medical claims submitted by covered entities with procedure code modifiers indicating the use of the 340B purchased drugs shall be adjusted by the 340B ceiling price. OHCA will adjust each claim by subtracting the 340B ceiling price from the amount reimbursed and multiplying the difference by the quantity submitted. OHCA will use the 340B ceiling price applicable to the quarter in which the claim is paid. Medical claims submitted by covered entities with a procedure code modifier indicating the use of non 340B purchased drugs will not be adjusted by the 340B ceiling price and will be submitted for federal rebates as required by CMS. Covered entities are required to use an appropriate procedure code modifier on all physician administered drug lines when submitting medical claims.

(3) If a 340B covered entity fails to pay quarterly adjustments invoiced by OHCA within forty-five (45) days of receipt, it may result in a debt to the State of Oklahoma subject to applicable interest pursuant to prompt payment methodology at OAC 260:10-3-3.

(4) The quarterly adjustments invoiced, including applicable interest, must be paid regardless of any disputes made by the covered entity. If a covered entity fails to pay OHCA

the adjustments invoiced within forty-five (45) days of receipt, the adjustments invoiced and applicable interest will be deducted from the facility's payment.

(d) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between the OHCA, the contract pharmacy, and the covered entity. These pharmacies will be subject to the recovery process stated in this Section.

# TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

## CHAPTER 55. MANAGED CARE

## SUBCHAPTER 1. GENERAL PROVISIONS

### 317:55-1-3. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

**"1115(a) IMD waiver"** means the 1115(a) Institutions for Mental Disease (IMD) demonstration waiver for individuals with Serious Mental Illness/Serious Emotional Disorder (SMI/SED) and Substance Use Disorder (SUD), as amended and including all active special terms and conditions (STCs) at a specific point in time, that authorizes Oklahoma Health Care Authority (OHCA) to operate a program in which one (1) or more requirements of Title XIX of the Social Security Act (Act) are waived based on the waiver authority of Section 1115 of the Act.

**"1915(c) waiver"** means any waiver, authorized by Section 1915(c) of the Act, that allows specific coverage of home and community-based services to a limited group of Medicaid-Eligible individuals as an alternative to institutional care.

**"Abuse"** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care (as defined at 42 C.F.R. § 455.2). It also includes Eligible and Health Plan Enrollee practices that result in unnecessary cost to the Medicaid program.

**"Accountable care organization"** or **"ACO"** means a network of physicians, hospitals, and other health care providers that provide coordinated care to Medicaid members.

**"Accrediting entity"** means an entity recognized by CMS under 45 C.F.R. § 156.275. Current CMS-recognized accrediting entities include Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC). To the extent CMS recognizes additional accrediting entities, OHCA will also permit the CE or DBM to achieve accreditation from such entity to meet the requirements.

**"Act"** means the Social Security Act.

**"Activities of daily living (ADL)"** means activities that reflect the Health Plan Enrollee's ability to perform self-care tasks essential for sustaining health and safety such as: bathing; eating; dressing; grooming; transferring (includes getting in and out of the tub, bed to chair, etc.); mobility; toileting and bowel/bladder control. The services help with proper medical care, self-maintenance skills, personal hygiene, adequate food, shelter, and protection.

**"Administrative remedies"** means an action taken by the OHCA in response to the DBM's failure to comply with a requirement or performance standard. Remedies, include but are not limit to, liquidated damages, capitation payment suspension, auto-assignment suspension, contract termination, and any other remedies outlined in the Contract.

**"Adult"** means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

**"American Indian/Alaska Native"** or **"AI/AN"** means any individual as defined in 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined Eligible as an Indian under 42 C.F.R. § 136.12.

**"Appeal"** means a review by an CE or DBM of an adverse benefit determination.

**"Applicant"** means an individual who seeks SoonerCare coverage.

**"Authorized representative"** means a competent adult who has the Enrollee's signed, written authorization to act on the Enrollee's behalf during the grievance, appeal, and state fair hearing process. The written authority to act will specify any limits of the representation.

**"Behavioral health services"** means a wide range of diagnostic, therapeutic and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

**"Business days"** means Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.

**"Calendar days"** means all seven (7) days of the week, including State of Oklahoma holidays.

**"Capitated contract"** means a contract between OHCA and a contracted entity for the delivery of services to Medicaid members in which OHCA pays a fixed, per-member per-month rate based on actuarial calculations.

**"Capitation payment"** means a payment OHCA will make periodically to the CE or DBM on behalf of each Health Plan Enrollee enrolled under the SoonerSelect program and based on the actuarially sound capitation rate for the provision of services under the State Plan and services under an approved In Lieu of Service or Setting (ILOS). OHCA shall make the payment regardless of whether the Health Plan Enrollee receives services during the period covered by the payment.

**"Capitation rate"** means the per Health Plan Enrollee, per-month amount, including any adjustments, that is paid by OHCA to the CE or DBM for each Health Plan Enrollee enrolled in the SoonerSelect program for the provision of services during the payment period.

**"Care coordination/care management"** means a process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the Health Plan Enrollee's needs using advocacy, communication, and resource management to promote quality and cost-effective interventions and outcomes. Based on the needs of the Health Plan Enrollee, the care manager arranges services and supports across the continuum of care, while ensuring that the care provided is person-centered.

**"Care manager"** means the CE's staff primarily responsible for delivering services to Health Plan Enrollees in accordance with its OHCA-approved risk stratification level framework, and meets the qualifications specified in the Contract.

**"Care plan"** means a comprehensive set of actions and goals for the Health Plan Enrollee developed by the care manager based on the unique needs of Health Plan Enrollee(s). The CE shall develop and implement care plans for all Health Plan Enrollees with a special health care need determined through the comprehensive assessment to need a course of treatment or regular care monitoring and in accordance with Section 1.8.3: "Care Plans" of the Contract.

**"Case file"** means an electronic record that includes Enrollee information regarding the management of health care services including but not limited to: Enrollee demographics; comprehensive assessment (if applicable); care plan; reassessments; referrals and authorizations and Enrollee case notes.

**"CEO"** means Chief Executive Officer.

**"Certified community behavioral health clinic"** or (**"CCBHC"** or **"CCBH"**) means entities designed to provide a comprehensive range of mental health and substance use disorder services as defined under the Excellence in Mental Health Act and certified by the Oklahoma Department of Mental Health and Substance Abuse Services.

**"C.F.R."** means the Code of Federal Regulations.

**"Child"** means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

**"Child welfare services"** means the Oklahoma Human Services (OKDHS) division responsible for administering Oklahoma's child welfare services.

**"Children's Health Insurance Program"** or **"CHIP"** means a Medicaid program authorized under Title XXI of the Social Security Act.

**"Children's Specialty Plan"** or **"Children's Specialty Program"** means the single statewide health care plan that covers all Medicaid services other than dental services and is designed to provide care to children in foster care children, former foster care children up to twenty-five (25) years of age, juvenile justice involved children, and children receiving adoption assistance.

**"Choice counseling"** means the provision of information and services designed to assist Eligibles in making enrollment decisions as described in 42 C.F.R § 438.2.

**"Chronic condition"** means a condition that is expected to last one (1) year or more and requires ongoing medical attention and/or limits activities of daily living (ADL).

**"Civil monetary damage"** means a damage imposed by OHCA which the CE must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700 et seq. Amounts may not exceed those specified in 42 C.F.R. § 438.704.

**"Clean claim"** means a properly completed billing form with coding based on Current Procedural Terminology (CPT), fourth edition or a more recent edition, the tenth revision of the International Classification of Diseases (ICD) or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS), where applicable, to provide information specifically required in the OHCA Provider Billing and Procedure Manual.

**"CMS"** means Centers for Medicare & Medicaid Services.

**"Commercial plan"** means an organization or entity that undertakes to provide or arrange for the delivery of health care services to Medicaid members on a prepaid basis and is subject to all applicable state and federal laws and regulations.

**"Continuity of care period"** means the ninety (90) day period immediately following an Enrollee's enrollment with the CE or DBM whereby established Enrollee and provider relationships, current services and existing prior authorizations and care plans shall remain in place.

**"Contract"** means a result of receiving an award from OHCA and successfully meeting all Readiness Review requirements, the agreement between the Contractor and OHCA where the Contractor will provide Medicaid services to SoonerSelect Enrollees, comprising of the Contract and any Contract addenda, appendices, attachments, or amendments thereto, and be paid by OHCA as described in the terms of the agreement.

**"Contract year"** means the period during which the Contract is in effect. The initial Contract year shall be from date of award through the end of the state fiscal year. Each subsequent Contract year shall be based on state fiscal year.

**"Contracted entity"** or **"CE"** means an organization or entity that enters into or will enter into a capitated contract with the Oklahoma Health Care Authority (OHCA) for the delivery of services that will assume financial risk, operational accountability, and statewide or regional functionality in this act in managing comprehensive health outcomes of Medicaid members. This includes an accountable care organization, a provider-led entity, a commercial plan, a dental benefit manager, or any other entity as determined by the OHCA.

**"Contractor"** means a contracted entity with which OHCA has entered into a binding agreement for the purpose of procuring services to SoonerSelect program Enrollees as specified in the Contract. The term "Contractor" includes all such Contractor's affiliates, agents, subsidiaries, any person with an ownership or control interest, officers, directors, manager, employees, independent contractors, and related parties working for or on behalf of the Contractor and other parties.

**"Copayment"** means a fixed amount that an Enrollee pays for a covered health care service when the Enrollee receives the service.

**"Corrective action plan"** or **"CAP"** means the detailed written plan that may be required by OHCA to correct or resolve a deficiency, event, or breach.

**"Cost sharing"** means the state's requirement that an Enrollee bear some of the cost of their care through mechanisms such as copayments, deductibles, and other similar charges.

**"Critical incident"** means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a SoonerSelect program Health Plan Enrollee.

**"Deemed newborn"** means children born to SoonerCare enrolled mothers and determined Eligible under 42 C.F.R. § 435.117.

**"Dental benefits manager"** or **"DBM"** means an entity that meets the definition of a Prepaid Ambulatory Health Plan (PAHP) as per 42 C.F.R. § 438.2 and is under contract with the OHCA to manage and deliver all services described in this SoonerSelect Dental Contract and who handles claims payment and prior authorizations and coordinates dental care with participating providers and Enrollees. Also referred to as a "Contractor".

**"Dental related emergency services"** means services provided to a SoonerSelect Dental Enrollee that are necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infections, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

**"Disenrollment"** means OHCA's removal of an Enrollee from participation in a specific CE or DBM or from participation in the SoonerSelect program.

**"Dual eligible individuals"** means individuals eligible for both Medicaid and Medicare.

**"Eligible"** means an individual who has been deemed Eligible for the SoonerSelect program but who is not yet enrolled in a CE or DBM.

**"Emergency medical condition"** means a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

**"Emergency services"** means medical services provided for a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably

expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

**"Encounter data"** means information relating to the receipt of any item(s) or service(s) by an Enrollee under the Contract that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

**"Enrollee"** means an individual who has been deemed Eligible for Medicaid in the State of Oklahoma, who has been deemed Eligible for enrollment in the SoonerSelect program, and who is currently enrolled in the SoonerSelect program.

**"Enrollee handbook"** means a guidebook that explains the SoonerSelect program that the Contactor shall distribute to every Enrollee. It shall be designed to help the Enrollee understand the CE or DBM, the SoonerSelect program and the rights and responsibilities that come with membership in the program.

**"Enrollment"** means the OHCA process by which an Eligible becomes an Enrollee with an CE or DBM.

**"Essential community provider"** means a provider defined by 45 C.F.R. § 156.235.

**"Excluded populations"** means populations that are excluded from participation in the SoonerSelect program as specified in the Contract.

**"Expansion adult"** means an individual nineteen (19) or older and under age sixty-five (65), with income at or below one hundred thirty-eight percent (138%) of the federal poverty level (FPL) determined Eligible in accordance with 42 C.F.R. § 435.119, and who are not categorically related to the aged, blind, and disabled.

**"Federally Qualified Health Center (FQHC)"** or **"Health Centers"** or **"Centers"** means an organization that qualifies for reimbursement under Section 330 of the Public Health Service Act. FQHCs qualify to receive enhanced reimbursements from Medicare and Medicaid, must serve an underserved population or area, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

**"Former foster care children"** or **"FFC"** means individuals under age twenty-six (26) determined Eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age eighteen (18) or aging out of foster care.

**"Foster care"** means planned, goal-directed service that provides twenty-four (24) hour a day substitute temporary care and supportive services in a home environment for children birth to eighteen (18) years of age in OKDHS custody.

**"Foster children (FC)"** means children in foster care under the responsibility of the State, including children and youth who are in State custody due to abuse or neglect.

**"FPL"** means federal poverty level.

**"Fraud"** means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**"Grievance"** means an Enrollee's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the Enrollee's rights regardless of whether remedial action is requested. A grievance includes an Enrollee's right to dispute an extension of time proposed by the CE or DBM to make an authorization decision.

**"Grievance and appeal system"** means the processes the CE or DBM must implement in accordance with 42 C.F.R. Part 438, Subpart F, to handle Enrollee grievances and appeals, as well as the processes to collect and track information about them.

**"Health care services"** means all services outlined in the Oklahoma Medicaid State Plan, the Alternative Benefit Plan, and the 1115(a) IMD Waiver that are provided, according to contract, by the CE or DBM in any setting. Health care services may include but are not limited to medical care, behavioral health care, dental care, and pharmacy services.

**"Health plan"** means the same in these rules as at 36 O.S. § 4405.1.

**"Hospitalization"** means care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

**"Implementation"** means the process by which OHCA and the CE or DBM performs actions and responsibilities to actively implement a managed care program or contract for the first time. Implementation also means, depending on its use, the moment in time that such actions and responsibilities are fully completed.

**"In Lieu of Service or Setting"** or **"ILOS"** means a service or setting that is provided to an enrollee as a substitute for a covered service or setting under the State plan. An ILOS can be used as an immediate or longer-term substitute for a covered service or setting under the State plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting under the State plan. An ILOS must be approvable as a service or setting through a waiver under section 1915(c) of the Act or a State plan amendment, including section 1905(a), 1915(i), or 1915(k) of the Act.

**"Indian health care provider"** or **"IHCP"** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

**"Initial enrollment"** means an Eligible's enrollment in an CE or DBM during the initial enrollment period.

**"Intermediate sanction(s)"** means the sanctions described in 42 C.F.R § 438.702, which the OHCA may impose for the contracted entities non-compliance for any of the conditions in 42 C.F.R. § 438.700.

**"Juvenile justice involved"** means any person in custody or under the supervision of the Oklahoma Office of Juvenile Affairs (OJA) for whom OJA is required to provide services by law or court order.

**"Manual"** or **"guide"** means any document, outside of the Medicaid State Plan, any Medicaid waiver, and the rules, that is created by or for OHCA for use in interpreting or implementing contractual terms. "Manual" is synonymous with guide, guidebook, companion guide, manual, reference book, dictionary, handbook, model, instructions, primer, workbook, or any other words denoting a document that is handled as a matter of convenience.

**"Medical necessity"** or **"medically necessary"** means a standard for evaluating the appropriateness of services as established under OAC 317:30-3-1.

**"National provider identifier (NPI)"** means a unique identification number for covered health care providers. Covered health care providers and all CEs, DBMs, and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical

specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

**"Non-compliance remedy"** means an action taken by OHCA in response to the Contractor's failure to comply with a contract requirement or performance standard.

**"Non-participating provider"** means a physician or other provider who has not contracted with or is not employed by the CE or DBM to deliver services under the SoonerSelect program.

**"Non-urgent sick visit"** means medical care given for an acute onset of symptoms which is not emergent or urgent, but which requires face-to-face medical attention within seventy-two (72) hours of Enrollee notification of a non-urgent condition, as clinically indicated. Examples of non-urgent sick visits include cold symptoms, sore throat, and nasal congestion.

**"OAC"** means Oklahoma Administrative Code.

**"OHCA"** means the Oklahoma Health Care Authority.

**"OJA"** means the Office of Juvenile Affairs.

**"OKDHS"** means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

**"Open enrollment period"** means the annual period of time, as defined by contract, when Enrollees and Eligibles can enroll in and select an CE or DBM for the SoonerSelect program.

**"O.S."** means Oklahoma Statutes.

**"Parent and caretaker relative"** means an individual determined Eligible under 42 C.F.R. § 435.110.

**"Participating provider"** means a physician or other provider who has a contract with or is employed by a CE or DBM to provide health care services to Enrollees under the SoonerSelect Medical or Dental program.

**"Post-stabilization care services"** means covered services related to an emergency medical condition that are provided after a Health Plan Enrollee is stabilized to maintain the stabilized condition or under the circumstances described in 42 C.F.R. § 438.114(e), to improve or resolve the Health Plan Enrollee's condition.

**"Pregnant women"** means women determined Eligible for SoonerCare under 42 C.F.R. § 435.116.

**"Prepaid Ambulatory Health Plan"** or **"PAHP"** means a DBM and/or an entity as per 42 C.F.R. § 438.2 that:

(A) Provides services to Enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates;

(B) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its Enrollees; and

(C) Does not have a comprehensive risk contract.

**"Prepaid dental plan"** means a contractual arrangement in accordance with 36 O.S. § 6142, whereby any prepaid dental plan organization undertakes to provide payment of dental services directly, or to arrange for prepaid dental services, or to pay or make reimbursement for any dental services not provided for by other insurance.

**"Prepaid dental plan organization"** means any person who undertakes to conduct one (1) or more prepaid dental plans providing only dental services in accordance with 36 O.S. § 6142.

**"Presumptive eligibility"** means a period of temporary SoonerCare eligibility for individuals who are categorically related to certain eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified entity, on the basis of applicant

self-attested income information, to meet the eligibility requirements for a Modified Adjusted Gross Income (MAGI) eligibility group.

**"Primary care"** means the provision of integrated, equitable, and accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

**"Primary care dentist"** or **"PCD"** means a dental care professional providing comprehensive dental care for a Dental Health Plan Enrollee.

**"Primary care provider"** or **"PCP"** means the following:

(A) Family medicine physicians in an outpatient setting when practicing general primary care;

(B) General pediatric physicians and adolescent medicine physicians in an outpatient setting when practicing general primary care;

(C) Geriatric medicine physicians in an outpatient setting when practicing general primary care;

(D) Internal medicine physicians in an outpatient setting when practicing general primary care (excludes internists who subspecialize in areas such as cardiology, oncology, and other common internal medicine subspecialties beyond the scope of general primary care);

(E) Obstetrics and gynecology physicians in an outpatient setting when practicing general primary care;

(F) Providers such as nurse practitioners and physicians' assistants in an outpatient setting when practicing general primary care; or

(G) Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting.

**"Prior authorization"** or **"PA"** means a requirement that an Enrollee, through the Enrollee's provider, obtain the CEs or DBM's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim.

**"Protected health information"** or **"PHI"** means information considered to be individually identifiable health information, per 42 C.F.R.§ 160.103.

**"Provider"** means a health care services provider licensed or certified in this State.

**"Provider agreement"** means an agreement between the CE or DBM and a participating provider that describes the conditions under which the participating provider agrees to furnish covered health care services to Enrollees.

**"Provider-led entity"** means an organization or entity that meets the criteria of at least one (1) of the following:

(A) A majority of the entity's ownership is held by Medicaid providers in this state or is held by an entity that directly or indirectly owns or is under common ownership with Medicaid providers in the state; or

(B) A majority of the entity's governing body is composed of individuals who:

(i) Have experience serving Medicaid members and:

(I) Are licensed in the state as physicians, physician assistants, nurse practitioners, certified nurse-midwives, or certified registered nurse anesthetists;

(II) At least one (1) board member is a licensed behavioral health provider; or

(III) Are employed by a hospital or other medical facility licensed by the state and operating in the state or an inpatient or outpatient mental health or substance abuse treatment facility or program licensed or certified by the state and operating in the state.

(ii) Represent the providers or facilities including, but not limited to, individuals who are employed by a statewide provider association; or
(iii) Are nonclinical administrators of clinical practices serving Medicaid members.

**"Quality Assessment and Performance Improvement"** or **"QAPI"** means a process designed to address and continuously improve CE and DBM quality metrics.

**"Risk contract"** means a contract between OHCA and a CE, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as those terms are defined at 42 C.F.R. § 438.2, under which the Contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the Contract.

**"Rural area"** means a county with a population of less than fifty thousand (50,000) people.

**"Rural Health Clinic"** or **"RHC"** means clinics meeting the conditions to qualify for RHC reimbursement as stipulated in Section 330 of the Public Health Services Act.

**"SoonerCare"** means the Oklahoma Medicaid program.

**"SoonerSelect"** means the CEs and DBMs with whom the OHCA contracts with to provide SoonerCare covered medical, dental, pharmacy, and behavioral health benefits.

**"Soon-To-Be-Sooner"** means Oklahoma's separate CHIP providing coverage to unborn children of families earning up to and including one hundred eighty-five percent (185%) of the FPL.

**"State Plan"** means an agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

**"Steady state operations"** or **"steady state"** means the time period beginning ninety (90) days after initial program implementation.

**"Third party liability"** or **"TPL"** means all or part of the expenditures for an Enrollee's medical or dental assistance furnished under the Oklahoma Medicaid State Plan that may be the liability of a third-party individual, entity, or program.

**"Urban area"** means a county with a population of fifty thousand (50,000) people or more.

**"U.S.C."** means United States Code.

**"Value-added benefit"** means any benefit or service offered by a CE or DBM when that benefit, or service is not a covered benefit per the State Plan. These benefits are subject to change annually as determined by the CE or DBM and OHCA.

**"Value-based payment arrangement"** means a payment arrangement between a CE or DBM and its participating providers when payment is intentionally aligned with quality measures OHCA applies to the CE or DBM.

**"Waste"** means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program; generally, not considered to be caused by criminally negligent actions but rather the misuse of resources.