Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
June 11th, 2026
1:00 – 3:00 PM
Charles Ed McFall Board Room

AGENDA

Please access via zoom:
https://www.zoomgov.com/webinar/register/WN_Hv_k88jhQCeSIzu0273SBA
Telephone: 1-669-254-5252 Webinar ID: 160 351 8122

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

II. Action Item: Approval of Minutes of March 5th, 2026: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

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

VI. Legislative Updates: **Bradley Downs, Legislative Liaison**

VII. Medicaid Directors Update: **Melissa Miller, State Medicaid Director**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Heather Cox, Deputy State Medicaid Director**

A. **APA WF#26-03 HR1 Alien Eligibility**
B. **APA WF#26-07 Nonpayment for Certain Gender Transitions Procedures**
C. **APA WF#26-10A&B Justice Involved Youth Reentry**

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

X. Next MAC Meeting: **Chairman, Jason Rhynes, O.D.**

July 9, 2026
September 3, 2026
November 5, 2026

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the March 5th, 2026, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

1. **Welcome, Roll Call, and Public Comment Instructions:**
   Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

   Delegates present were: Mr. Nick Barton, Ms. Joni Bruce, Mr. Brett Coble (virtual), Dr. Steven Crawford, Ms. Wanda Felty, Dr. Autumn Hurd, Dr. Daniel Post, Dr. Jason Rhynes (virtual), providing a quorum.

   Alternates present were: Dr. Sherrita Polk (virtual), Dr. Syeachia Dennis, Dr. Eve Switzer, providing a quorum.

   Ex-officio members present: Ms. Kimrey McGinnis

   ***Delegates absent without an alternate were*:** Ms. Janet Cizek

   Ex-officio members not present: Ms. Madison Miller, Mr. Tracy Ellis

2. **Approval of January 8th, 2026, Minutes**
   Medical Advisory Committee
   The motion to approve the minutes was by Dr. Steven Crawford, seconded by Dr. Eve Switzer and passed unanimously.

3. **MAC Member Comments/Discussion:**

   Dr. Switzer asked if the MAC has discussed code G2211, an outpatient primary care code. She also emailed Ms. Miller and Dr. Rhynes prior to the committee meeting regarding this matter.

   Dr. Crawford introduced former OHCA staff who were in attendance.

4. **State Medicaid Director Update**
   Melissa Miller, State Medicaid Director

   Budget Update: Ms. Miller provided a brief update on OHCA's current budget status, which is currently at $500 million for SFY 2027. OHCA is working diligently and engaging frequently with members of the legislature to explain the needs of the program and how OHCA got to that number. Included in OHCA's budget are FMAP reduction, projected increased in utilization for traditional and expansion populations, and increases due to rural health transformation.

   Patient Panels: OHCA continues to work with the managed care entities and primary care providers to help explain and understand what the issues are. Initial rosters were sent out by OHCA. Ms. Miller added that there are specific limitations on how individuals can be moved on panels, including

federal requirements, patient choice, and claims-based logic review by managed care entities. OHCA understands there are ongoing issues that providers are experiencing; the team is working with them on those.

H.R.1 Implementation: OHCA continues to participate in ongoing conversations with other states, as well as with federal partners. The final regulatory language will not be ready until June. Ms. Miller reminded the committee that the community engagement requirements are expected to impact about 86,000 of Oklahoma's Medicaid expansion members, and the six-month redeterminations are expected to affect approximately 190,000 expansion members, and the most imminent change will affect about 4,000 qualified alien refugee individuals. OHCA did confirm that its Insure Oklahoma program will not be subject to the work requirements.

Call Center: OHCA is working to implement an AI chatbot and a member app with live chat within the next few months in hopes to reduce the call volume and overall workload and not have to temporarily close the call center every Tuesday. Ms. Miller added that staff are aware that there are some delays on the provider contract renewals side. Provider contracts staff are currently working on 14,000 contract renewals but hope that changes to staff and processes will help streamline workflow.

Rural Health Transformation: The Feds officially approved the entire award, so the money is available. OHCA, as well as OSDH and other agencies involved are working on getting contracts and RFPs out the door so work can begin for Rural Health. Vice-Chairwoman Felty asked if the changes will impact the DHS and their online system. Ms. Miller stated that it will not affect ABD, these changes are for the expansion population.

5. <u>Change of Service Provision:</u>
Stephanie Mavredes, Deputy State Medicaid Director

Ms. Mavredes presented the following seventeen Change of Service Provisions. As a reminder, she stated that the SoonerSelect contracts have language in them that requires the plans to ask for OHCA review and approval when they deviate from the current OHCA process, which is represented by the change of service provisions listed below. The MAC is not required to vote on these items.

i. Remove Prior Authorization for Nursing Assessment and Evaluation Code T1001
ii. Remove Prior Authorization for Incontinence Supplies for Codes A4335, A4927, T4521, T4522, T4523, T4524, T4529, T4530, T4533, T4543, T4525, T4526, T4527, T4528, T4531, T4532, T4534, T4544, T4535, T4537, T4540, T4541, T4542
iii. Remove Prior Authorization for Doppler Velocimetry Code 76821
iv. Remove Prior Authorization Enteral Nutrition Infusion Pump Codes B9002, B9004, B9006
v. Remove Prior Authorization for Neurobehavioral Stats Exam Code 96116
vi. Remove Prior Authorization for CT scan and Visit for Codes 71271, G0296

vii. Remove Prior Authorization for Certain Codes for Hearing Aids for Codes 92628, 92629, 92631, 92632, 92634, 92635, 92642
viii. Remove Prior Authorization for Diagnostic Ultrasounds for Codes 76815, 76816, 76817, 76818, 76819, 59025
ix. Remove Prior Authorization for Compression Burn Garment for Code 6512
x. Remove Prior Authorization for Implantable Pumps for Codes 95990 and 95991
xi. Process Change for ABA Assessment for Codes 97151 and 97151-TS
xii. Change of Requirements for ABA Supervision
xiii. Add Prior Authorization for Air Transport for Codes A0430 and A0435

For more detailed information, see Attachment A of the Committee packet.

6. Financial Update

Tasha Black, Senior Director of Budget and Accounting

Ms. Black presented the SFY2026 financial transactions through the month of November. Ms. Black stated that OHCA was under budget in revenues and expenditures, with revenues, accounting for receivables, at $4.1 billion under budget and expenditures, accounting for encumbrances at $4. 092 billion under budget. The primary driver for the $7.3 million positive variance is attributed to the Medicaid program spend, representing $100.6 million of the total variance. On the revenue side, outside of the federal matching funds, OHCA was also under budget in healthcare enhancement appropriation by $3.6 million, medical refunds by $15.8 million, taxes and fees by $5.4 million, and over budget in drug rebates by $3.1 million.

For more detailed information, see Attachment B of the committee packet.

7. Legislative Update

Bradley Downs, Legislative Liaison

Mr. Downs provided a brief update on several bills that OHCA is tracking and recent budget discussions. He added that this year, OHCA is primarily focused on the budget and working with the bill authors to ensure the agency's stance is known. OHCA met with the legislative appropriations leadership a couple of weeks ago and asked OHCA to create several appropriations scenarios for $150 million, $250 million, $350 million, and a full appropriation. OHCA's financial team is currently working on those scenarios.

Bills discussed:

- HB 2059 – directs OHCA to partner with OU Health Sciences Center to provide coverage for prescription medication for certain inmates who are in county or municipal correctional facilities. Ms. Miller added that this will have a direct impact on the agency, but will not have a direct Medicaid program impact.

- SB 1566 – revises Medicaid requirements for ABA treatment of autism by codifying that an out-of-state BCBA could supervise via telehealth. There has been some discussion on this bill pertaining to OHCA's fiscal impact. As of right now, OHCA does not have a formal fiscal impact on this, as OHCA does not have the actuarial capacity to tie any sort of increase in utilization to this specific bill. The MCOs are working diligently, not only with OHCA, but with legislative parters to keep them aware of any sort of financial impact that this change will have.
- SB 1565 – requires OHCA to add in nutrition support into the Transforming Maternal Health Grants. OHCA has been working with Sen. Stanley, bill author, as well as Mom's Meals, to modify the language so that it's permissive language rather than mandatory language.
- HJR 1067 – a potential constitutional amendment to allow the legislature to not cover lost Medicaid costs if federal matching funds are reduced below 90% and would require a vote of the people. Dr. Crawford asked for clarification regarding fiscal impact. Mr. Downs stated that he would get back with the committee on this bill, as it was just received that morning.
- HB 4423 – requires OHCA to report applicants for Medicaid, whose citizenship is unable to be verified to the Attorney General for subsequent potential reporting to ICE. Due to the sensitive nature of the issue, OHCA is getting input from its legal team to inform the Speaker and Pro Tem's offices on any sort of potential conflicts with federal law.
- HB 3650 – Modifies the end date of OHCA's Medicaid minimum rate provisions for reimbursement from the MCOs to providers who don't opt into value-based arrangements. The current end date is July 1, 2027. The bill would extend that one year making the deadline July 1, 2028.

Dr. Crawford requested clarification on SB 1836, as he believed the requirement for physicians to provide certain mental health screening instruments was already being covered. Ms. Miller stated that she believes it is because OHCA allows it. This change would require it at a certain frequency, so OHCA would expect and anticipate an increased billing of the code.

The next deadline is March 28, 2026, and requires bills to be off the floor of their chamber of origin.

8. <u>Discussion and Possible Action: MAC Charter and Bylaws</u>
Chairman, Jason Rhynes, O.D.

Ms. Miller provided a brief overview of the MAC Charter and Bylaws and highlighted the major changes:

- The addition of a managed care plan association representative
- The addition of a required number of MATF members
- Term limits will be set at four years
- State agency reps will be non-voting members and will not count towards the quorum
- Hybrid meeting option – in-person and virtual

Vice-Chairwoman Felty asked that the language under item #5 Alternates be updated to clarify who appoints the alternate. Ms. Miller suggested the following language:

The appointing authority shall consider feedback from the MAC member and/or Organization when selecting an alternate.

The motion to approve the change to the bylaw language was by Dr. Steven Crawford, seconded by Dr. Eve Switzer and passed unanimously.

The motion to approve the amended MAC Charter and Bylaws was by Dr. Steven Crawford, seconded by Dr. Daniel Post and passed unanimously.

For more detailed information, Attachment C of the Committee packet.

9. **New Business:**

Vice-Chairwoman, Wanda Felty.

No new business was discussed.

10. **Adjourn:**

Vice-Chairwoman, Wanda Felty.

Ms. Wanda Felty asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Dr. Daniel Post; there was no dissent and the meeting adjourned at 2:10pm.

June 11, 2026 MAC
Proposed Rule Amendment Summary

The following proposed **EMERGENCY** rules were previously presented at Tribal Consultation.

The Agency is requesting the effective date to be immediately upon receiving gubernatorial approval for the following item:

APA WF #26-07 Nonpayment for Certain Gender Transition Procedures — The proposed revisions implement Senate Bill 904, now codified at Section 1-800 of Title 63 of the Oklahoma Statutes. The revision adds language providing that OHCA does not reimburse for or provide coverage of gender transition procedures, as defined by Section 1-800 of Title 63. This prohibition applies regardless of whether the procedure is provided to a minor or an adult. The statutory definition excludes behavioral health services or mental health counseling, medications to treat depression or anxiety, certain medications used to treat precocious or delayed puberty, certain services related to disorders of sex development, treatment of complications, and emergency treatment. The law became effective upon passage and approval pursuant to the emergency clause.

Budget Impact: Budget neutral.

Emergency Justification: These revisions are necessary to avoid violation of state law.

The Agency is requesting an effective date of July 1, 2026, or upon gubernatorial approval, for the following item:

APA WF #26-10A&B Justice-Involved Youth Reentry — The proposed rule revisions implement Section 5121 of the Consolidated Appropriations Act, 2023. The amendment requires states to provide certain Medicaid-covered services to eligible justice-involved youth under age 21, and former foster care youth up to age 26, during the 30 days prior to release from incarceration. Required services include physical and behavioral health screenings and diagnostic services, as well as targeted case management provided 30 days prior to release and 30 days post-release. Planning efforts and services will be coordinated in partnership with the Office of Juvenile Affairs, Department of Corrections, Department of Human Services, and Department of Mental Health and Substance Abuse Services.

Budget Impact: The estimated total cost for SFY27 is $192,625, with $64,294 in state share. The estimated total cost for SFY28 is $466,184, with $155,600 in state share. The state share will be covered by OJA and ODMHSAS.

Emergency Justification: These revisions are necessary to implement the federal mandate, Section 5121 of the Consolidated Appropriations Act, 2023.

The Agency is requesting an effective date of October 1, 2026, or upon gubernatorial approval, for the following item:

APA WF #26-03 HR1 Alien Eligibility — The proposed policy revisions align with eligibility changes included in H.R. 1, also referred to as the Working Families Tax Cut legislation. Beginning October 1, 2026, federal financial participation (FFP) will only be available for Medicaid benefits furnished to United States citizens, lawful permanent residents (LPRs), certain Cuban/Haitian entrants, and citizens of the Freely Associated States covered under the Compact of Free

Association (COFA). Most other non-citizens will no longer qualify for full-scope coverage and will be limited to Emergency Medical Assistance.

Budget Impact: Budget neutral.

Emergency Justification: The proposed emergency rules are needed for compliance with federal law.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

317:35-5-25. Citizenship/noncitizen status and identity verification requirements

(a) **Citizenship/noncitizen status and identity verification requirements.** Verification of citizenship/noncitizen status and identity is required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) passport;

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS)(Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a Beneficiary Earnings and Data Exchange (BENDEX) or State Data Exchange (SDX) screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one (1) of the fifty (50) states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986. For Puerto Ricans whose eligibility is being determined for the first time on or after October 1, 2010 and using a birth certificate to verify citizenship, the birth certificate must be a certified birth certificate issued by Puerto Rico on or after July 1, 2010;

(ii) A Consular Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of Birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen Identification Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the former INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);
(vi) A final adoption decree showing the child's name and U.S. place of birth;
(vii) Evidence of U.S. Civil Service employment before 6/1/1976;
(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);
(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;
(x) Oklahoma voter registration card;
(xi) Other acceptable documentation as approved by OHCA; or
(xii) Other acceptable documentation to the same extent as described and communicated by the United States Citizenship and Immigration Service (USCIS) from time to time.

(B) Other less reliable forms of citizenship verification are:
(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date and that indicates a U.S. place of birth. For children under sixteen (16) the evidence must have been created near the time of birth or five (5) years before the date of application;
(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth;
(iii) Federal or state census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or
(iv) One (1) of the following items that show a U.S. place of birth and was created at least five (5) years before the application for SoonerCare. This evidence must be one (1) of the following and show a U.S. place of birth:
(I) Seneca Indian tribal census record;
(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;
(III) U.S. State Vital Statistics official notification of birth registration;
(IV) An amended U.S. public birth record that is amended more than five (5) years after the person's birth; or
(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:
(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;
(B) A school identification card with a photograph of the individual;
(C) An identification card issued by federal, state, or local government with the same information included on driver's licenses;
(D) A U.S. military card or draft record;
(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;
(G) A U.S. Coast Guard Merchant Mariner card;
(H) A state court order placing a child in custody as reported by the OKDHS;
(I) For children under sixteen (16), school records may include nursery or daycare records;
(J) If none of the verification items on the list are available, an affidavit may be used for children under sixteen (16). An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

(b) **Reasonable opportunity to obtain verification.**

(1) The state provides Medicaid to citizens and nationals of the United States and certain noncitizens, including during a reasonable opportunity period pending verification of citizenship, national status, or immigrations status. The reasonable opportunity period begins on the date the notice of reasonable opportunity is received by the individual and extends at minimum ninety (90) days. Receipt by the individual is deemed to occur five (5) days after the date on the notice, unless the individual shows that the notice was not received in the five-day period. The state provides an extension of the reasonable opportunity period if the individual subject to verification is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the state needs more time to complete the verification process. The state begins to furnish benefits to otherwise eligible individuals on the date of application containing the declaration of citizenship or immigration status and throughout the reasonable opportunity period.

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five (5) years before the initial application date that indicates a U.S. place of birth. For children under the age of sixteen (16), the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two (2) affidavits by two (2) individuals who have personal knowledge of the event(s) establishing the applicants/member's claim of citizenship;
(ii) At least one (1) of the individuals making the affidavit cannot be related to the applicant or member;
(iii) In order for the affidavit to be acceptable, the persons making them must be able to provide proof of their own citizenship and identity;
(iv) If the individual(s) making the affidavit has information which explains why

evidence establishing the applicant's/member's claim of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Noncitizen eligibility.** ~~SoonerCare services are provided as described to the defined groups as indicated in this subsection if they meet all other factors of eligibility, including but not limited to residency requirements, and if the relevant noncitizen status is verifiable by federally approved means.~~ SoonerCare services are provided to noncitizens only as described in this subsection, if the individual meets all other applicable eligibility requirements, including but not limited to residency requirements, and the relevant immigration status or category is verified by federally approved means. Effective October 1, 2026, full SoonerCare benefits for noncitizens are limited to individuals for whom federal financial participation is available under Section 1903(v)(5) of the Social Security Act and other applicable federal law.

~~(1) **Unauthorized resident noncitizen.** An unauthorized resident noncitizen is a foreign-born individual who is not lawfully present in the United States, regardless of having had authorization during a prior period. Unauthorized resident noncitizens have formerly been known as "illegal" or "undocumented" immigrants or "aliens". Per 8 U.S.C. 1611(a) and (b)(1)(A) an unauthorized resident noncitizen is ineligible for Title XIX Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an unauthorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate Children's Health Insurance Program (CHIP) for services that benefit the unborn child, if the unborn child meets all eligibility requirements.~~

~~(2) **Authorized resident noncitizen, not qualified.** An authorized resident noncitizen is a foreign-born individual who is lawfully present in the United States (U.S.) and is lawfully residing in the U.S., but who does not meet the definition of qualified noncitizen, per 8 U.S.C. 1611(a) and (b)(1)(A). The Oklahoma Medicaid program does not exercise the CHIPRA 214 option; therefore, an authorized resident noncitizen is ineligible for Title XIX or Title XXI Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an authorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate CHIP for services that benefit the unborn child, if the unborn child meets all eligibility requirements.~~

~~(3) **Qualified noncitizen.** A "qualified noncitizen" is an authorized resident noncitizen who, at the time of applying for Medicaid, has a "qualified noncitizen" immigration status as identified at 8 U.S.C. 1641, as may be amended from time to time. Any qualified noncitizen is eligible for full Title XIX Medicaid benefits after a five-year waiting period beginning on the date of the noncitizen's entry into the U.S. with an immigration status identified as "qualified noncitizen" if the noncitizen meets all other eligibility criteria at the end of the waiting period. During the waiting period, as per 8 U.S.C. 1613(a), any qualified noncitizen is eligible to receive emergency Medicaid as described in subparagraph (e) below if the noncitizen meets all other eligibility requirements, including but not limited to residency requirements.~~

~~(A) **Qualified noncitizen immigration statuses.** Immigration statuses identified by federal law as "qualified noncitizen", as of November 2, 2021, include:~~

(i) A noncitizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [INA], per 8 U.S.C. 1101 et seq.;
(ii) A noncitizen who is granted asylum under INA section 208, per 8 U.S.C. 1158;
(iii) A noncitizen who is admitted to the U.S. under INA section 207 refugee, per 8 U.S.C. 1157;
(iv) A noncitizen who is paroled into the U.S. under INA section 212(d)(5), per 8 U.S.C. 1182(d)(5), for a period of at least one (1) year;
(v) A noncitizen whose deportation is being withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);
(vi) A noncitizen who is granted conditional entry before 1980 pursuant to INA section 203(a)(7), per 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;
(vii) A noncitizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);
(viii) A noncitizen who, or whose parent or child, has been battered or subjected to extreme cruelty in the U.S. by a U.S. citizen or lawful permanent resident spouse or parent or by a member of the spouse's or parent's family residing in the same household, except during any period in which the individual responsible for such battery or cruelty resides in the same household or family eligibility unit as the individual subjected to such battery or cruelty and only when the alien meets all of the following requirements:
(I) The noncitizen, if not the individual subjected to battery or extreme cruelty, had no active participation in the battery or cruelty;
(II) The noncitizen is a credible victim; and
(III) The noncitizen is able to show a substantial connection between the need for benefits sought and the batter or extreme cruelty; and
(IV) The noncitizen has been approved or has a petition pending which sets forth a prima facie case for one of the following: status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); classification under INA 204(a)(1)(B)(ii) or (iii); suspension of deportation under INA 244(a)(3); status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); or classification under INA 204(a)(1)(B); or cancellation of removal under INA 240A(b)(2).
(ix) A noncitizen who is or has been a victim of a severe form of trafficking in persons and who has been granted nonimmigrant status under INA 101(a)(15)(T) or who has a pending application that sets forth a prima facie case for eligibility for such immigration status; or
(x) Beginning December 27, 2020, a noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

(B) **Five-year wait exception for refugees and asylees.**

(i) Excepted from the five-year waiting period per 8 U.S.C. 1612(b)(2)(A), the following qualified noncitizens are immediately eligible for a Medicaid determination upon the date:

(I) A noncitizen is admitted to the U.S. as a refugee under INA section 207 [INA 207 Refugee], per 8 U.S.C. 1157;

(II) A noncitizen is granted asylum under INA section 208, per 8 U.S.C. 1158;

(III) A noncitizen's deportation is withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);

(IV) A noncitizen is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980); or

(V) A noncitizen is admitted to the U.S. as an Amerasian immigrant under the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, section 584.

(ii) This exception to the five-year waiting period expires seven (7) years after the date of action indicated in the list at (c)(3)(B)(i) above. Upon expiration of the exception, the five-year waiting period must be calculated.

(C) **Five-year wait exception for certain permanent resident noncitizens.** The five-year waiting period does not apply and the noncitizen is immediately eligible for a Medicaid determination per 8 U.S.C. 1612(b)(2)(B), if:

(i) The noncitizen is lawfully admitted to the U.S. for permanent residence;

(ii) The noncitizen has either:

(I) worked forty (40) qualifying quarters of coverage as defined under the Act; or

(II) can be credited with such qualifying quarters as provided under 8 U.S.C. 1645; and

(iii) In the case of any such qualifying quarters creditable for any period beginning after December 31, 1996, the noncitizen did not receive any federal means-tested public benefit during any such period.

(D) **Five-year wait exception for veteran and active-duty noncitizens.** As per 8 U.S.C. 1612(b)(2)(C) and 1613, the five-year waiting period does not apply, and the noncitizen is immediately eligible for a Medicaid determination if the noncitizen is a qualified noncitizen who is lawfully residing in the state and is:

(i) A veteran (as defined at INA sections 101, 1101, or 1301, or as described at 38 U.S.C. section 107) with a discharge characterized as an honorable discharge and not on account of noncitizenship and who fulfills the minimum active-duty service requirements of 38 U.S.C. section 5303A(d);

(ii) On active duty (other than active duty for training) in the Armed Forces of the United States; or

(iii) The spouse or unmarried dependent child of an individual described herein as a veteran or active-duty noncitizen; or

(iv) The unremarried surviving spouse of an individual described herein as a veteran or active-duty noncitizen who is deceased, if the marriage fulfills the requirements of 38 U.S.C. section 1304.

(E) **Five-year wait exception for COFA migrants.** Per 8 U.S.C. 1613(b)(3) and as of December 27, 2020, any noncitizen who lawfully resides in the state in accordance with

the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau is, with regard to the Medicaid program, are not subject to the five-year waiting period unless and until the individual=s status is adjusted to lawful permanent resident (LPR), at which time the five year waiting period must be calculated, unless the individual meets a separate exception to the five-year waiting period:

(i) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred before December 27, 2020, then the waiting period begins on the date of adjustment and ends after five (5) years;

(ii) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period expires on December 27, 2025; and

(iii) If the individual entered the U.S. after December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period begins on the date of entry into the U.S. and ends after five (5) years.

(F) **Five-year wait exception for qualified noncitizens receiving SSI.** Per 8 U.S.C. 1612(b)(2)(F), a qualified noncitizen who is receiving benefits under the supplemental security income program (SSI) under Title XVI of the Act shall be eligible for medical assistance under a state plan under Title XIX of the Social Security Act, per 42 U.S.C. 1396 et seq), under the same terms and conditions that apply to other recipients of SSI benefits.

(4) **Special categories of noncitizens and conferred benefits.** For the following noncitizens, federal law has expressly authorized Title XIX Medicaid benefits as described below and at law.

(A) **Certain American Indian / Alaskan Native (AI/AN) noncitizens.** The qualified noncitizen requirement and the five-year waiting period do not apply to any individual who is:

(i) An American Indian born in Canada to whom section 289 of the Immigration and Nationality Act apply, per 8 U.S.C. 1359; or

(ii) A member of a federally recognized Indian tribe as defined at 25 U.S.C. 450b(e).

(B) **Certain Iraqi nationals.**

(i) Public Law 110-181, Section 1244, while in force and as amended from time to time, created a new category of special immigrant for Iraqi nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government, while employed by or on behalf of the U.S. government in Iraq, for not less than 1 year beginning on or after March 20, 2003, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment; (II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, extended Iraqi special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009.

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Iraqi nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(C) **Certain Afghan nationals.**

(i) Public Law 111-8, Section 602, while in force and as amended from time to time, created a new category of special immigrant for Afghan nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government or the International Security Assistance Force, while employed by or on behalf of the U.S. government in Afghan, for not less than one (1) year beginning on or after October 7, 2001, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment;

(II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, amended Public Law 111-8, Section 602, to extend Afghan special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009;

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Afghan nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(iv) Pursuant to Public Law 117-43, Section 2502, while in force and as may be amended from time to time, "applicable individuals" have time-limited eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [See subsection (c)(3)(B) above], until March 21, 2023, or the term of parole, whichever is later. In this subparagraph, the term "applicable individual" includes only:

(I) A citizen or national of Afghanistan or a person with no nationality who last habitually resided in Afghanistan, if the individual is paroled into the U.S. between July 31, 2021, and September 30, 2022;

(II) The spouse or child of an individual described at (c)(3)(C)(iv)(I) of this section, if the spouse or child is paroled into the U.S. after September 30, 2022; and

(III) The parent or legal guardian of an individual described at (c)(3)(C)(iv)(I) who is determined to be an unaccompanied child, if the parent or legal guardian is paroled into the U.S. after September 30, 2022.

(D) **Certain Ukrainian nationals**. Public Law 117-128, Section 401, while in force and as amended from time to time, created a new category of special immigrant for Ukraine nationals, including:

(i) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States between February 24, 2022 and September 30, 2023; or

~~(ii) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States after September 30, 2023, and is the spouse or child of an individual described in (D)(i)(I) above, or is the parent, legal guardian, or primary caregiver of an individual described in (D)(i)(I) above who is determined to be an unaccompanied child; and~~

~~(iii) The individual's parole has not been terminated by the Secretary of Homeland Security.~~

(1) **Noncitizens eligible for full SoonerCare benefits**. Beginning October 1, 2026, a noncitizen is eligible for full SoonerCare benefits without a five-year waiting period only if the individual is:

(A) a Cuban or Haitian entrant, as defined by federal law;

(B) a Compact of Free Association migrant lawfully residing in the United States in accordance with federal law; or

(C) a lawfully admitted permanent resident who is not subject to the five-year waiting period or who is exempt from that waiting period under applicable federal law.

(2) **Noncitizens eligible for full SoonerCare benefits after the five-year waiting period.** Beginning October 1, 2026, a lawfully admitted permanent resident who is subject to the five-year waiting period is eligible for full SoonerCare benefits only after satisfying the applicable waiting period and all other eligibility requirements under federal and state law.

(3) **Noncitizens ineligible for full SoonerCare benefits.** Beginning October 1, 2026, a noncitizen who is not described in paragraph (1) or (2) of this subsection is not eligible for full SoonerCare benefits, except to the extent coverage is expressly authorized by federal law. Such individuals may be eligible for emergency Medicaid if otherwise eligible under subsection (e) of this section. This paragraph includes, but is not limited to, a noncitizen whose verified immigration status or category is any of the following and who is not otherwise described in paragraph (1) or (2) of this subsection:

(A) a refugee admitted under section 207 of the Immigration and Nationality Act;

(B) an individual granted asylum under section 208 of the Immigration and Nationality Act;

(C) a noncitizen paroled into the United States for a period of at least one (1) year;

(D) a noncitizen granted withholding of deportation or withholding of removal;

(E) a noncitizen granted conditional entry prior to April 1, 1980;

(F) a noncitizen who, or whose parent or child, has been battered or subjected to extreme cruelty, as described by federal law;

(G) a noncitizen granted nonimmigrant status as a victim of trafficking, a noncitizen with a pending application that sets forth a prima facie case for such status, or a victim of a severe form of trafficking in persons and qualifying family members, as described by federal law;

(H) an Amerasian immigrant;

(I) a lawfully residing veteran, active-duty servicemember, or qualifying family member whose eligibility is based solely on that status and who is not otherwise described in paragraph (1) or (2) of this subsection;

(J) an American Indian born in Canada or an American Indian who is a member of a federally recognized tribe, if the individual is not a United States citizen and is

not otherwise described in paragraph (1) or (2) of this subsection;
(K) a certain Afghan parolee described by federal law;
(L) a certain Ukrainian parolee described by federal law; or
(M) any other lawfully residing noncitizen not otherwise described in paragraph (1) or (2) of this subsection.

(4) **Unauthorized resident noncitizens.** An unauthorized resident noncitizen is not eligible for full SoonerCare benefits and may receive emergency Medicaid only, if otherwise eligible.

(d) **Continuing conformance with federal law.** ~~Notwithstanding any other provision of this section, any noncitizen population that federal law or authority, as amended from time to time, identifies as eligible for medical assistance under Title XIX is eligible for such benefits to the same extent, under the same conditions, and for the same period of time as indicated in the relevant federal law or official federal guidance documents, including any amendments to the law or guidance.~~Notwithstanding any other provision of this section, eligibility of noncitizens for full SoonerCare benefits, any applicable waiting period, and the availability of emergency Medicaid shall be determined in accordance with applicable federal law, as amended from time to time, and federal financial participation shall be claimed only to the extent permitted by federal law.

(e) **Emergency Medicaid.** ~~Emergency Medicaid in this section means medical assistance provided to a noncitizen under Title XIX for care and services that are necessary for the treatment of an emergency medical condition, as defined by section 1903(v)(3) of the Act and including labor and delivery but not related to organ transplant procedure, of the noncitizen involved if the noncitizen otherwise meets eligibility requirements for medical assistance under the state plan, including but not limited to residency requirements.~~ Emergency Medicaid means medical assistance provided to a noncitizen under Title XIX for care and services necessary for the treatment of an emergency medical condition, as defined by Section 1903(v)(3) of the Social Security Act, including labor and delivery but not related to an organ transplant procedure, if the noncitizen otherwise meets eligibility requirements under the state plan, including but not limited to residency requirements.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES

317:30-3-1. Creation and implementation of rules; applicability

(a) Medical rules of the Oklahoma Health Care Authority (OHCA) are set by the OHCA Board. The rules are based upon the recommendations of the Chief Executive Officer of the Authority, the Deputy State Medicaid Director, the State Medicaid Director, OHCA Tribal partners and the OHCA Medical Advisory Committee. The State Medicaid Director is responsible for implementing medical policies and programs and directing the Fiscal Agent regarding proper payment of claims.

(b) Payment to practitioners under Medicaid is made for services clearly identifiable as personally rendered services performed on behalf of a specific member. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(c) Payment is made on behalf of Medicaid eligible individuals for services within the scope of the Authority medical programs. Services cannot be paid under Medicaid for ineligible individuals or for services not covered under the scope of medical programs or that do not meet documentation requirements. These claims will be denied, or in some instances upon post-payment review, payment will be recouped. In accordance with Section 1-800 of Title 63 of the Oklahoma Statutes, OHCA does not reimburse for or provide coverage of gender transition procedures.

(d) Payment to practitioners on behalf of Medicaid eligible individuals is made only for services that are medically necessary and essential to the diagnosis and treatment of the patient's presenting problem. Wellness examinations and diagnostic testing are not covered for adults unless specifically set out in coverage guidelines.

(e) The scope of the medical program for eligible children is the same as for adults except as further set out under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service guidelines.

(f) Services, provided within the scope of the Oklahoma Medicaid program, shall meet medical necessity criteria. Requests by qualified providers for services in and of itself shall not constitute medical necessity. The OHCA shall serve as the final authority pertaining to all determinations of medical necessity. Some service limits listed within OAC 317:30 can be exceeded for expansion adults, upon meeting medical necessity as determined by OHCA and in alignment with the Oklahoma Medicaid State Plan. Physical therapy, occupational therapy and speech language pathology have hard limits**,** which are set at forty-five (45) visits for both habilitation and rehabilitation B a cumulative total of 90 visits [fifteen (15) visits of each therapy]. Members must meet medical necessity criteria, prior authorization, and all other documentation requirements. Medical necessity is established through consideration of the following standards:

(1) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

(2) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records and other supporting records, evidence sufficient to justify the member's need for the service;
(3) Treatment of the member's condition, disease or injury must be based on reasonable and predictable health outcomes;
(4) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family, or medical provider;
(5) Services must be delivered in the most cost-effective manner and most appropriate setting; and
(6) Services must be appropriate for the member's age and health status and developed for the member to achieve, maintain, or promote functional capacity.

(g) Emergency medical condition means a medical condition including injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

(h) Verbal or written interpretations of policy and procedure in singular instances is made on a case-by-case basis and shall not be binding on this Agency or override its policy of general applicability.

(i) The rules and policies in this Part apply to all providers of service who participate in the program.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240.1. Definitions

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

"Accrediting body" means one (1) of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations;

(F) Accreditation Commission for Health Care (ACHC); or

(G) Other OHCA approved accreditation.

"Adult" means an individual twenty-one (21) and over, unless otherwise specified.

"AOD" means alcohol and other drug.

"AODTP" means alcohol and other drug treatment professional.

"ASAM" means the American Society of Addiction Medicine.

"ASAM patient placement criteria (ASAM PPC)" means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

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

"BHAs" means behavioral health aides.

"Carceral Facility" means a facility in which an eligible juvenile or former foster care youth is considered an inmate of a public institution under 42 C.F.R. § 435.1010, including but not limited to:

(A) State-owned, operated, or contracted prisons;

(B) Community correction centers and ODOC contracted halfway houses;

(C) City and county jails;

(D) County-operated juvenile detention centers;

(E) Secure detention and treatment facilities;

(F) Tribal jails and tribal-operated juvenile detention facilities;

"Certifying agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

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

"Child" means an individual younger than twenty-one (21), unless otherwise specified.

"Client Assessment Record (CAR)" means the standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of the member as per the OHCA prior authorization manual on the OHCA'S website at www.oklahoma.gov/ohca.

"CM" means case management.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"EBP" means an evidence-based practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment benefit for children. In addition to screening services, EPSDT also covers the diagnostic and treatment services necessary to ameliorate acute and chronic physical and mental health conditions.

"FBCS" means facility-based crisis stabilization.

"FSPs" means family support providers.

"ICF/IID" means intermediate care facility for individuals with intellectual disabilities.

"Institution" means an inpatient hospital facility or institution for mental disease (IMD).

"IMD" means institution for mental disease as per 42 C.F.R. § 435.1009 as a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age twenty-one (21) receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under sixty-five (65) years of age [Section 1905(a)(24)(B) of the Social Security Act].

"Level of functioning rating" means a standardized mechanism to determine the intensity or level of services needed based upon the severity of the member's condition. The CAR level of function rating scale is the tool that links the clinical assessment to the appropriate level of Mental Health treatment. Either the Addiction Severity Index (ASI) or the Teen Addiction Severity Index (TASI), based on age, is the tool that links the clinical assessment to the appropriate level of Substance Abuse (SA) treatment.

"LBHP" means a licensed behavioral health professional.

"MST" means the EBP Multi-Systemic Therapy.

"OAC" means the publication authorized by 75 Oklahoma Statutes, Sec. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time limited.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance use disorder treatment services, and contract directly with the Oklahoma Health Care Authority to provide outpatient behavioral health services.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"O.S." means Oklahoma Statutes.

"RBMS" means residential behavioral management services within a group home or therapeutic foster home.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self-defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

"PRSS" means peer recovery support specialist.

"SAMHSA" means the Substance Abuse and Mental Health Services Administration.

"Serious emotional disturbance (SED)" means a condition experienced by persons from birth to eighteen (18) that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(C) The child must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(V) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

"Serious mental illness (SMI)" means a condition experienced by persons age eighteen (18) and over that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

(C) The adult must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations).

(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-241.6. Behavioral health targeted case management

Payment is made for behavioral health targeted case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) **Description of behavioral health case management services.** Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target groups for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons, and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be authorized based on established medical necessity criteria.

(A) The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring, and advocacy

on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community but may take place in the behavioral health case manager's office, if more appropriate.

(B) The provider will coordinate transition services with the member and family (if applicable) by phone or face to face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan.

(C) Case managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two (2) business days of the missed appointments. Community/home-based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one (1) time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(D) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(E) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(F) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian [if the member is under eighteen (18)], the behavioral health case manager, and an LBHP or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

(G) SoonerCare reimbursable behavioral health case management services include the following:

(i) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(ii) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(iii) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(iv) Supportive activities such as non-face-to-face communication with the member and/or parent/guardian/family member.

(v) Non-face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(vi) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(viii) Behavioral health targeted case management is available to individuals transitioning from institutions to the community, ~~[~~except individuals who are inmates of public institutions~~]~~. This exclusion does not apply to eligible juveniles under the age of twenty-one (21) and former foster care youth under the age of twenty-six (26) who reside in carceral facilities as defined in OAC 317:30-5-240.1 and are within thirty (30) days of projected release. Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) **Levels of case management.**

(A) Standard case management/resource coordination services are targeted to adults with serious mental illness or children with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case management/resource coordination is limited

to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

(B) Intensive case management (ICM) is targeted to adults with serious and persistent mental illness in PACT programs. To ensure that these intense needs are met, caseloads are limited to between ten (10) to fifteen (15) members. The ICM shall: be a certified behavioral health case manager II; have a minimum of two (2) years' behavioral health case management experience; have crisis diversion experience; have attended the ODMHSAS six (6) hour ICM training and be available twenty-four (24) hours a day. ICM is limited to fifty-four (54) units per member per month.

(C) Wraparound facilitation case management (WFCM) is targeted to children with significant mental health conditions being treated in a System of Care (SOC) Network who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need of more intensive case management services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high-fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. Staff providing WFCM must meet the requirements for the SOC/WFCM. WFCM is limited to fifty-four (54) units per member per month.

(3) **Excluded services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

(A) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;

(B) Managing finances;

(C) Providing specific services such as shopping or paying bills;

(D) Delivering bus tickets, food stamps, money, etc.;

(E) Counseling, rehabilitative services, psychiatric assessment, or discharge planning;

(F) Filling out forms, applications, etc., on behalf of the member when the member is not present;

(G) Filling out SoonerCare forms, applications, etc.;

(H) Mentoring or tutoring;

(I) Provision of behavioral health case management services to the same family by two (2) separate behavioral health case management agencies;

(J) Non-face-to-face time spent preparing the assessment document and the service plan paperwork;

(K) Monitoring financial goals;

(L) Leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded individuals.** The following SoonerCare members who are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), OJA, OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:

(A) Members/families (when applicable) for whom at-risk case management services are available through OKDHS and OJA staff;

(B) Members in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;
(C) Residents of ICF/IIDs and nursing facilities unless transitioning into the community;
(D) Members receiving targeted case management services under a Home and Community Based Services (HCBS) waiver program;
(E) Members receiving case management through the ADvantage waiver program;
(F) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC);
(G) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE);
(H) Members receiving Early Intervention case management (EICM);
(I) Members receiving case management services through certified school-based targeted case management (SBTCM) providers;
(J) Members receiving partial hospitalization services; or
(K) Members receiving MST.

(5) **Filing requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and an LBHP or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(A) Date;
(B) Person(s) to whom services are rendered;
(C) Start and stop times for each service;
(D) Original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];
(E) Credentials of the service provider;
(F) Specific service plan needs, goals, and/or objectives addressed;
(G) Specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals, and/or objectives;
(H) Progress and barriers made towards goals, and/or objectives;
(I) Member/family (when applicable) response to the service;
(J) Any new service plan needs, goals, and/or objectives identified during the service; and
(K) Member satisfaction with staff intervention.

(7) **Case management travel time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-268. Limitations

(a) The following are non-billable opportunities for CCBHCs serving eligible members:

(1) Employment services;
(2) Personal care services;
(3) Childcare;
(4) Respite services; and
(5) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:

(1) Members residing in a nursing facility or ICF/IID;
(2) Inmates of a public correctional institution~~; and~~ unless the inmate:
(A) Is in the custody of a carceral facility as defined in OAC 317:30-5-240.1; and
(B) Is under the age of twenty-one (21) or a former foster care youth up to the age of twenty-six (26) pursuant to Section 5121 of the Consolidated Appropriations Act of 2023; and
(C) Is within thirty (30) days of projected release and eligible to receive medically necessary screening, diagnostic, and targeted case management services.
(3) SoonerCare members being served by a PACE provider.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

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~~

(1) 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 individuals with intellectual disabilities and meet all other eligibility requirements.

(2) To juveniles under the age of twenty-one (21) and former foster care youth up to the age of twenty-six (26) in the custody of a carceral facility as defined in OAC 317:30-5-240.1 who are eligible to receive targeted case management (TCM) services thirty (30) days prior to projected release and 30 days following release.

(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 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-45. Eligibility for inmates

(a) The Oklahoma Health Care Authority (OHCA) shall receive applications from and make eligibility determinations for individuals residing in correctional institutions, including juvenile facilities. However, the SoonerCare program will only pay for services rendered to individuals residing in a correctional institution as specified in Oklahoma Administrative Code (OAC) 317:35-5-26.

(b) In accordance with federal law, including, but not limited to, 42 United States Code (U.S.C.) § 1396a(a)(84), individuals residing in correctional institutions who are under the age of twenty-one (21) or who meet the former foster care child requirements found at OAC 317:35-5-2, shall have their eligibility suspended for the duration of the incarceration period, except for periods of time that inpatient services are provided as specified in OAC 317:35-5-26.

(c) The effective date of the suspension is the calendar day following the date on which an individual described in (b) of this section becomes incarcerated.

(d) A redetermination of eligibility for an individual described in (b) of this section shall be conducted prior to release to determine if the individual continues to meet the eligibility requirements for SoonerCare. A new application will not be required to redetermine eligibility.

(e) Suspended eligibility shall be restored to the release date after a redetermination of eligibility, when:

(1) The Oklahoma Department of Human Services (OKDHS), using the release date supplied by the Oklahoma Office of Juvenile Affairs (OJA) or the Oklahoma Department of Corrections (DOC), removes the suspension;

(2) The individual reports his or her release to the Oklahoma Health Care Authority (OHCA) within ten (10) calendar days of the release date; or

(3) The individual reports his or her release to OHCA more than ten (10) calendar days from the release date, and there is good cause for the delay in reporting.

(f) Qualifying juveniles under the age of twenty-one (21) and former foster care youth up to the age of twenty-six (26) in the custody of a carceral facility within thirty (30) days of projected release are eligible to receive medically necessary screening, diagnostic, targeted case management, and other covered Medicaid state plan services required under applicable federal law and state plan provisions.