

OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
March 30, 2022, at 3:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK. 73105

AGENDA

Public access via Zoom:

https://okhca.zoom.us/webinar/register/WN_rqa1_6kYRiGgncbPITIJMA

Telephone: 1-669-900-6833 Webinar ID: 879 9466 0401

*Please note: Since the physical address for the OHCA Board Meeting has resumed, any livestreaming option provided is provided as a courtesy. Should such livestreaming option fail or have technical issues, the OHCA Board Meeting will not be suspended or reconvened because of this failure or technical issue.

1. Call to Order / Determination of Quorum.....Marc Nuttle, Chair
2. Consent Agenda.....Marc Nuttle, Chair
 - a) Approval of the November 17, 2021 OHCA Board Meeting Minutes (Attachment "A")
 - b) Discussion and Approval of State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:1-3-4 (Attachment "B")
 - c) Discussion and Vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:10-1-16.
 - i. IT Consulting Services (Attachment "C")
3. Chief Executive Officer's ReportKevin Corbett, Chief Executive Officer
4. Chief Operating Officer's ReportMelody Anthony, Chief Operating Officer
State Medicaid Director
 - a) Member Moment
 - b) Public Health Emergency Flexibilities, Traylor Rains, Deputy State Medicaid Director (Attachment "D")
5. Discussion of Report from the PharmacyTerry Cothran, DPh
Advisory Committee and Possible Action RegardingSenior Pharmacy Director
Drug Utilization Board Recommendations
 - a) Pharmacy Overview, Terry Cothran, D.Ph., Senior Pharmacy Director (Attachment "E")
 - b) Discussion and Possible Action on Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.1, § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:2-1-11 (Attachment "F"):
 - i. Jakafi® (Ruxolitinib) and Rezurock™ (Belumosudil)
 - ii. Bylvay™ (Odevixibat)
 - iii. Lupkynis™ (Voclosporin) and Saphnelo™ (Anifrolumab-fnia)
 - iv. Abecma® (Idecabtagene Vicleucel), Farydak® (Panobinostat), and Pepaxto® (Melphalan Flufenamide)
 - v. Jemperli® (Dostarlimab-gxly)
 - vi. Opzelura™ (Ruxolitinib 1.5% Cream)
 - vii. Livmarli™ (Maralixibat)
 - viii. Byooviz™ (Ranibizumab-nuna Intravitreal Injection) and Susvimo™ (Ranibizumab

- ix. Intravitreal Implant)
- ix. Empaveli™ (Pegcetacoplan)
- x. Evkeeza® (Evinacumab-dgnb) and Leqvio® (Inclisiran)
- xi. Myfembree® (Relugolix/ Estradiol/Norethindrone)
- xii. Tyrvaya™ (Varenicline Nasal Spray)

6. Discussion of Report from the.....Phil Kennedy
 Compliance Advisory Committee Chair, Compliance Advisory Committee

7. Discussion of Report of Administrative.....Susan Dell’Osso
 Rules Advisory Committee and Possible Action Chair, Administrative Rules Advisory Committee
 Regarding Agency Rulemaking (Attachment “G”)

- a) Consideration and Vote on Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act and in accordance with 75 O.S. § 253. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment “G”):
 - i. APA WF 22-01 Non-Emergency Transportation (NEMT) Driver Compliance
 - ii. APA WF 22-02 Independent Clinical Psychologist Services for Adults
- b) Consideration and Vote on Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Permanent Rules (Attachment “G”)
 - iii. APA WF 21-01 Reimbursing Federally Qualified Health Centers (FQHCs) for Long-Acting Reversible Contraceptives (LARCs) Outside of the Encounter Rate
 - iv. APA WF 21-02A OHS ADvantage Waiver Services and State Plan Personal Care Services
 - v. APA WF 21-02B OHS ADvantage Waiver Services and State Plan Personal Care Services
 - vi. APA WF 21-04 Diabetes Self-Management Education and Support (DSMES) Services
 - vii. APA WF 21-05A Medicaid Expansion and Durable Medical Equipment
 - viii. APA WF 21-05B Medicaid Expansion
 - ix. APA WF 21-06 Insure Oklahoma and Timely Filing
 - x. APA WF 21-07 Payments from Trusts for Clothing Expenses Not Counted as Income
 - xi. APA WF 21-08 Statewide HIE (OKSHINE)
 - xii. APA WF 21-09 Supplemental Hospital Offset Payment Program (SHOPP) Revisions
 - xiii. APA WF 21-10 Transitioning Developmental Disabilities Services Division (DDSD) Members back into the Money Follows the Person (MFP) Demonstration
 - xiv. APA WF 21-11 Indian Health Service, Tribal and Urban Indian (I/T/U) Shared Savings Program
 - xv. APA WF 21-12 Purchasing Rules Revisions
 - xvi. APA WF 21-13 Grievance Procedures and Process Rule Revisions
 - xvii. APA WF 21-14 Expansion Adults into SoonerCare Choice
 - xviii. APA WF 21-15 Ensuring Access to Medicaid Act
 - xix. APA WF 21-16 Hospital Presumptive Eligibility (HPE) for Expansion Adults
 - xx. APA WF 21-17 Dental Revisions
 - xxi. APA WF 21-19 Appeals to the Chief Executive Office (CEO)/Administrative Law Judge (ALJ)
 - xxii. APA WF 21-20 Alternative Treatments for Pain Management
 - xxiii. APA WF 21-22 Title XXI Dental Revision for Pregnant Women
 - xxiv. APA WF 21-26 COFA Migrant Medicaid Extension and Afghan Refugees Eligibility Determinations
 - xxv. APA WF 21-27 Timely Filing Policy Cleanup
 - xxvi. APA WF 21-28 Qualified Medicare Beneficiary Plus (QMBP) Policy Clarification
 - xxvii. APA WF 21-29 Partial Hospitalization Program (PHP) Services for Adults
 - xxviii. APA WF 21-30 Eliminate Community Based Extended (CBE) and Community Based Transitional (CBT) Levels of Care

- xxix. APA WF 21-31 Applied Behavior Analysis (ABA) Revisions
- xxx. APA WF 21-32 Obstetric (OB) Ultrasound Coverage
- xxxi. APA WF 21-33 Improve 340B Shared Savings Methodology
- xxxii. APA WF 21-34 Reimbursement methodology for Providers of Certified Community Behavioral Health (CCBH) Services
- xxxiii. APA WF 21-35 Lodging and Meals Revisions
- xxxiv. APA WF 21-37 Private Duty Nursing (PDN) Revisions
- xxxv. APA WF 21-38A Developmental Disabilities Services (DDS) Updates for Specialized Foster Care, Agency Companion, Employment Services and Self-Directed Services
- xxxvi. APA WF 21-38B Developmental Disabilities Services (DDS) Updates for Specialized Foster Care, Agency Companion, Employment Services and Self-Directed Services
- xxxvii. APA WF 21-39 Laboratory Services
- xxxviii. APA WF 21-40 Pregnant Women Copayment Language Cleanup
- xxxix. APA WF 21-41A Outdated/Obsolete Policy Language Cleanup
 - xl. APA WF 21-41B Outdated/Obsolete Policy Language Cleanup
 - xli. APA WF 21-42 Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) Visit Limitation Revisions
 - xl.ii. APA WF 21-43 Opioid Treatment Provider (OTP) Policy Changes
 - xl.iii. APA WF 21-45 Referrals for Specialty Services Revisions

8. Adjournment.....Marc Nuttle, Chair

NEXT BOARD MEETING
 May 18, 2022 at 2:00PM
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd
 Oklahoma City, OK 73105

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MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
November 17, 2021
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on November 16, 2021 at 3:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on November 12, 2021 at 3:01 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 4:05 p.m.

BOARD MEMBERS PRESENT: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Dell’Osso, Member DeMarco, Member Kennedy,

BOARD MEMBERS ABSENT: Member Boyd, Member Nuttle

ITEM 2 / PUBLIC COMMENT ON THIS MEETING’S AGENDA ITEMS BY ATTENDEES WHO GAVE 24-HOUR PRIOR WRITTEN NOTICE

Stanley Hupfeld, OHCA Board Chairman

- Allison LeBoeuf, Osteopathic Association
- Jennifer McCullum, Membership of the Alliance of Mental Health Providers of Oklahoma
- Steven Crawford, Oklahoma Academy of Family Physicians
- Anthony Sykes, Coalition of Medical Associations
- Lynn Means, Oklahoma Dental Association

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF CONSENT AGENDA WHICH INCLUDES:

Member DeMarco requested that item 3b be removed from the consent agenda for further discussion

- a) Approval of the August 26, 2021, OHCA Board Meeting Minutes (Attachment “A”)
- c) Discussion and Vote regarding the Authority’s ability to withstand the procurement decision made by the CEO based on the Authority’s budget and available funds pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:10-1-16.
 - i. Third Party Liability (Attachment “C”)
 - ii. MyHealth (Attachment “D”)
 - iii. Prior Authorization RFP (Attachment “E”)
 - iv. Pondera (Attachment “F”)

MOTION: Member DeMarco moved for approval of the Consent Agenda, with the exception of item 3b, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Dell’Osso, Member DeMarco, Member Kennedy

BOARD MEMBERS ABSENT: Member Boyd, Member Nuttle

- b) Approval of State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:1-3-4 (Attachment “B”)
 - i. CCBHC PPS Rebasing Methodology
 - ii. Intensive Residential Substance Use Disorder Treatment for Adolescents Rate
 - iii. Developmental Disabilities Services Increases
 - iv. ADvantage Waiver Services Rate Increases

Member DeMarco moved to approve item 3b.i-ii as published and also moved to approve item 3b.iii-iv, subject to OHS obtaining a provider attestation stating that the extra 20% of retroactive amount will be used for payroll related costs.

MOTION:

Member Demarco moved for approval of item 3b of the Consent Agenda, as published. The motion was seconded by Member Dell'Osso.

FOR THE MOTION:

Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Dell'Osso, Member DeMarco, Member Kennedy

BOARD MEMBERS ABSENT:

Member Boyd, Member Nuttle

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT

Kevin Corbett, Chief Executive Officer

CEO Corbett provided an update on COVID-19, Expansion, Regulatory, Medicaid Delivery System, Board Responsibility and Authority, and Team Member Recognition.

COVID-19 Update: To date, there have been about 93,000 positive COVID infections, with 9% of that being Medicaid members. Of the 93,000, 13,988 have been hospitalized. Unfortunately, deaths account for about 5% of the Medicaid members, mainly due to the age of our members. OHCA staff are currently analyzing vaccination rates among Medicaid members. Early indication suggests there is a lower vaccination rate. Other states are also seeing lower vaccination rates. Efforts to encourage vaccinations are currently underway.

Since the beginning of the pandemic, 68 OHCA staff have tested positive, two of which resulted in hospitalization. Of the 68, 48 are teleworkers and 20 are in office staff. There have been zero COVID infections in the last 30 days. OHCA has hosted four vaccine clinics with the most recent being November 16. Staff are also assessing the interest in a children's vaccine clinic.

Expansion Update: About 216,000 members have been added through OHCA's Expansion efforts. OHCA has enrolled 138,821 of the 200,000 true new member targets set by OHCA. OHCA staff have worked hard to achieve this. CEO Corbett also thanked OHCA's community partners, who also worked tirelessly to help new members enroll. OHCA's Communication Department is working to reach and conduct outreach to the counties that have low enrollment. Data shows that there are counties that have low provider coverage. OHCA staff is working to get those areas better covered through education and outreach. Utilization shows that laboratory, clinic, outpatient, physician, and prescription services were the top services received.

Data also shows that total cost for expansion members is \$285 million and \$215 million for new expansion members. Average cost per member for expansion members is \$2,314 and \$2,708 for new expansion members. The estimates used for budget purposes fall in line with the current cost per member.

Regulatory Update: At the beginning of the pandemic, Oklahoma had the opportunity to participate in an enhanced federal matching program, the first one being the 6.2% that was created by the First Family Coronavirus Act. Oklahoma also had the opportunity to participate in the American Rescue Plan 5% Expansion opportunity. The estimates show that all those that participate in the Medicaid Program will have received about \$1.3 billion from the start of the enhanced funding period until the end of when the funding will occur. It is expected that the 6.2% enhanced funding will cease at the end of the Public Health Emergency, which is expected to terminate in January 2022 so the funding would end in March 2022. The American Rescue Plan funding will occur for the next two years. To date, Oklahoma has received over \$600 million in enhanced funding. A large portion of the \$600 million will go to OHCA. SHOPP Hospitals are expected \$125 million and nursing facilities are expected to receive about \$64 million. OHCA estimates that \$285 million will be utilized to cover the cost of which the program was intended to cover. One of the requirements OHCA had agreed to not terminate or disenroll member that become ineligible during the process under the 6.2% funding opportunity. The process of disenrolling members that are no longer eligible will likely begin 30-days after the Public Health Emergency has terminated. A wind-down process is being developed.

Vaccine Mandates: OHCA has reviewed and determined that the OSHA mandate for employers with 100 employees or more does not apply to OHCA, as OHCA is not an employer within the meaning of the term used in the rule. The CMS mandate for CMS-certified facilities also does not apply to OHCA, as there is no mandated responsibility of the state Medicaid agency under the rule. The federal funding received for the Medicaid program in Oklahoma does not bring OHCA within the meaning of a federal contractor under the President Biden Executive Order mandate. OHCA is working with CMS to better understand OHCA's role as a Medicaid payer, in the event of non-compliance with the CMS mandate.

Medicaid Delivery System: Following the Supreme Court ruling, OHCA ceased all Managed Care activities. OHCA began a series of conversations with the Governor's office and the leadership of the House and Senate and agreed to go through a discussion process to consider all alternatives to change the delivery system. The process started with a group of legislators selected by the House and Senate to represent them. There have also been discussions with key stakeholders – MCOs, ACOs, providers, health systems (including Academic Health Systems), and others.

Board Responsibilities and Authority: A formal request for opinion from the Attorney General regarding the board's responsibility and authority has been submitted.

Team Member Recognition: Chairman Hupfeld read the following resolutions:

Mike Herndon Resolution: Whereas, Mike Herndon, has served 16 years as a dedicated employee of the Oklahoma Health Care Authority; and Whereas, Mike Herndon has been a servant leader serving in various leadership capacities for OHCA, primarily as the state's Chief Medical Officer; and Whereas, Mike Herndon distinguished himself with his deep knowledge and abilities related to SoonerCare, and the expertise and leadership developed during that career has been invaluable to OHCA; and Now Therefore, Be It Resolved, the Board of Directors hereby expresses its gratitude to Mike Herndon for all he contributed to OHCA. Further Resolved, the Board of Directors wishes Mike Herndon continued success in all his endeavors and expresses our hope for his continued health, happiness, and prosperity. Further Resolved, a copy of this resolution be presented to Mike Herndon as a token of our respect and gratitude.

Melinda Thomason Resolution: Whereas, Melinda Thomason, has served more than 20 years as a dedicated employee of the Oklahoma Health Care Authority; and Whereas, Melinda Thomason has been a valuable member of the OHCA team, serving a various leadership capacities, most recently as Senior Director for Stakeholder Engagement; and Whereas, during her Tenure, millions of Oklahomans have received SoonerCare benefits; and Whereas, over a 20 year career, Melinda Thomason distinguished herself with her deep knowledge and abilities related to SoonerCare, and the expertise and leadership developed during that career has been invaluable to OHCA; and Now Therefore, Be It Resolved, the Board of Directors hereby expresses its gratitude to Melinda Thomason for all she has contributed to OHCA. Further Resolved, the Board of Directors wishes Melinda Thomason continued success in all her endeavors and expresses our hope for her continued health, happiness, and prosperity. Further Resolved, a copy of this resolution be presented to Melinda Thomason as a token of our respect and gratitude.

Vice-Chairman Yaffe asked CEO Corbett to commit to the board and members of the public to not use SB 131 as legislative authority to pass Third Party Managed Care. CEO Corbett stated he will not take any action until OHCA has gone through the process of diligence and selected an approach that has been agreed to by the Governor's office. Vice-Chairman asked for CEO Corbett to clarify his statement. CEO Corbett stated that OHCA will not proceed with anything that OHCA is going to do without legislative authority. Vice-Chairman Yaffe asked if CEO Corbett thought OHCA has legislative authority to proceed with Third Party Managed Care. CEO Corbett stated that will be a decision by the process that OHCA is going through today and added that he believes OHCA has the authority to move forward with Third Party Managed Care. Vice-Chairman Yaffe asked why the board was put into the position to vote on something that was not fully vetted. CEO Corbett stated that the diligence process did take place and is now being taking place even further with those that are willing to participate as potential partners. Vice-Chairman asked what law would be in violation of, should the board not promulgate rules related to SB 131. CEO Corbett stated that the law itself. SB 131 has an obligation to this board to promulgate rules for that Act. That law became effective September 1, 2021. Member Case asked what the penalty would be should the rule not be approved. CEO Corbett stated that OHCA is an organization that has significant requirements to comply with several laws and regulations and it is his directive to everyone that OHCA comply with all laws applicable to us. He is unsure what the consequence is and does not want to know what the consequence would be should the rule not be approved.

Chairman Hupfeld stated it was his opinion that the board is doing the right thing. Member Kennedy concurred with Chairman Hupfeld's opinion.

ITEM 5 / CHIEF OF STAFF'S REPORT

Ellen Buettner, Chief of Staff

Ms. Buettner provided an update on the Human Capital Management System, which focuses mainly on performance, accountability, and career growth. Over the past couple of years, they have implemented an annual statewide engagement survey. The survey indicated that OHCA had a 79% engagement rate, as compared to last years rate of 86%. Jennifer Lamb-Hornsby has been conducting post survey focus groups to dig into the survey feedback. A couple of takeaways to address some of the issues are to: identify ways to build better connections with the team and the Connect Committee is going to focus on initiatives with gratitude challenges and network events. Key initiatives are being identified and being shared with the agency.

Ms. Buettner added that OHCA is going to participate in an agency deep dive with the state COO, Steve Harpe. This day long session will be held with the larger state agencies to talk through Human Capital Management, finance, business processes, and strength and weaknesses. From that, OHCA hopes to discuss and identify some specific areas for improvement and develop specific metrics.

Ms. Buettner stated that Katelynn Burns will be representing the agency at the Capitol, during legislative session. OHCA has one bill from last year that will be brought over to this legislative session, related to Third Party Liability program, but at this time, OHCA does not plan to request additional legislation.

ITEM 6 / CHIEF OPERATING OFFICER'S REPORT

Melody Anthony, State Medicaid Director/Chief Operating Officer

Ms. Anthony provided a NAMD Federal Policy update. There are three areas that the federal government focuses on: maintaining coverage of access, equity, and whole person care; all of which are things that are also important to OHCA. For more detailed information, see attachment "G" of the board packet. As part of Ms. Anthony's update and member moment, a staff video was played during the meeting.

ITEM 7 / COMPREHENSIVE QUALITY STRATEGY UPDATE

Nathan Valentine, MD, CPE, FAAFP, Chief Quality Officer

Dr. Valentine provided an update on OHCA's Comprehensive Quality Strategy (CQS), which provided a CQS overview and an update on the CQS framework, CQS process, and CQS activities. For more detailed information, see attachment "H" of the board packet.

ITEM 8 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE

Phil Kennedy, Chair of the Compliance Advisory Committee

Committee Chairman Kennedy introduced Aaron Morris, Chief Financial Officer, to provide an update on the items discussed during the November 10th Compliance Committee Meeting.

Mr. Morris provided an overview of SFY 2021 Financial Year in Review, which included information on variance, revenue, expenses, admin spending, budget, a five-year review, growth breakout, FMAP, 340 cash balance, SFY22 financial report, and SFY 23 budget request.

ITEM 5i-v / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS

Randy G. Curry, D.Ph., Chair of the Pharmacy Advisory Committee

Action Item – a) Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 to Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e) (see Attachment "I")

- i. Cabometyx® (Cabozantinib), Fotivda® (Tivozanib), Jelmyto® (Mitomycin), and Padcev® (Enfortumab Vedotin-ejfv)
- ii. Zilxi® (Minocycline 1.5% Topical Foam)
- iii. Kynmobi™ (Apomorphine) and Ongentys® (Opicapone)
- iv. Fetroja® (Cefiderocol) and Kimyrsa™ (Oritavancin)
- v. Xywav® (Calcium/Magnesium/Potassium/ Sodium Oxybates)
- vi. Alkindi® Sprinkle (Hydrocortisone Oral Granule), Eysuvis® (Loteprednol 0.25% Ophthalmic Suspension), Gimoti® (Metoclopramide Nasal Spray), Nextstellis® (Drospirenone/Estetrol Tablet), Ozobax® (Baclofen 5mg/5mL Oral Solution), Phexxi® (Lactic Acid/Citric Acid/Potassium Bitartrate Vaginal Gel), RediTrex® (Methotrexate Injection), Reltone™ (Ursodiol Capsule), and Thyquidity™ (Levothyroxine Oral Solution)
- vii. Nulibry™ (Fosdenopterin)
- viii. Danyelza® (Naxitamab-ggqk) and Truseltiq™ (Infigratinib)
- ix. Feraheme® (Ferumoxytol), Injectafer® (Ferric Carboxymaltose), and Monoferric® (Ferric Derisomaltose)
- x. Herceptin® (Trastuzumab) and Margenza® (Margetuximab-cmkb)
- xi. Orgovyx™ (Relugolix)

MOTION:

Member Curry moved for approval of item 9i-xi, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION:

Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Dell'Osso, Member DeMarco, Member Kennedy

BOARD MEMBERS ABSENT:

Member Boyd, Member Nuttle

ITEM 10i-xii / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING

Susan Dell'Osso, Chairwoman of the Administrative Rules Advisory Committee

Member Dell'Osso introduced Traylor Rains, Deputy State Medicaid Director, to provide an overview of the rules, listed below. Member Case was concerned with how section 317:55-3-1, item c: Mandatory Specialty Children's Plan Enrollment, opt out and quoted "eligible in the following categories will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan". Her concern is with the word 'the', as it predisposes that there will only be one. Mr. Rains stated that it was determined during the process that only one specialty plan would be selected.

Member Case recommended that APA WF #21-15 be pulled out and voted on separately.

- a) Consideration and Vote on Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act and in Accordance with 75 O.S. § 253. OHCA Requests the Adoption of the Following Emergency Rules (see attachment "J"):
- i. APA WF #21-01 Reimbursing Federally Qualified Health Centers (FQHCs) for Long-Acting Reversible Contraceptive (LARCs) Devices Outside of the Encounter Rate
 - ii. APA WF #21-05 Medicaid Expansion and Durable Medical Equipment
 - iii. APA WF #21-10 Transitioning Developmental Disabilities Services Division (DDSD) Members back into the Money Follows the Person (MFP) Demonstration
 - iv. APA WF #21-11 Indian Health Service, Tribal and Urban Indian (I/T/U) Shared Savings Program
 - v. APA WF # 21-13 Grievance Procedures and Process Rule Revisions
 - vii. APA WF #21-16 Hospital Presumptive Eligibility (HPE) for Expansion Adults
 - viii. APA WF #21-17 Adult Dental Benefit Revisions
 - ix. APA WF #21-19 Appeals to the Chief Executive Officer (CEO)/Administrative Law Judge (ALJ)
 - x. APA WF 21-20 Alternative Treatments for Pain Management
 - xi. APA WF #21-22 Title XXI Dental Revision for Pregnant Women
 - xii. APA WF #21-26 COFA Migrant Medicaid Extension and Afghan Refugees Eligibility

MOTION:

Member Dell'Osso motioned for approval of item 10a.i-v & vii-xii as published. The motion was seconded by Member Kennedy.

FOR THE MOTION:

Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Dell'Osso, Member DeMarco, Member Kennedy

BOARD MEMBERS ABSENT:

Member Boyd, Member Nuttle

- vi. APA WF # 21-15 Ensuring Access to Medicaid Act

Vice-Chairman Yaffe asked how the language for APA WF #21-15 was created. Mr. Rains stated he believed the language was in SB 131. Vice-Chairman Yaffe asked Mr. Rains what the outcome would be should the board not approve this rule. Mr. Rains stated he would defer that question to General Counsel and the Attorney General's office and would also depend on who is enforcing it. CEO Corbett reiterated that it is his expectation that this organization comply with all laws and regulations. Vice-Chairman stated that it is nuanced. CEO Corbett stated that was an assumption of Vice-Chairman Yaffe, that OHCA is trying to implement rules that are required by law. He restated that OHCA has made no decision to do anything with regard to utilizing that law.

MOTION:

Member Dell'Osso motioned for approval of item 10a.vi, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION:

Chairman Hupfeld, Member Dell'Osso, Member DeMarco, Member Kennedy

AGAINST THE MOTION:

Vice-Chairman Yaffe, Member Case, Member Curry

BOARD MEMBERS ABSENT:

Member Boyd, Member Nuttle

ITEM 11 / DISCUSSION AND POSSIBLE ACTION REGARDING OHCA BOARD MEETING DATES AND TIMES FOR CLENDAR YEAR 2022

Stanley Hupfeld, OHCA Board Chairman

MOTION: Member Dell'Osso motioned for approval of the 2022 OHCA Board Meeting Dates and Times, as published. The motion was seconded by Member DeMarco.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Curry, Member Dell'Osso, Member DeMarco, Member Kennedy

BOARD MEMBER ABSTAIN: Vice-Chairman Yaffe

BOARD MEMBERS ABSENT: Member Boyd, Member Nuttle

ITEM 12 / DISCUSSION AND POSSIBLE ACTION: ELECTION OF THE 2022 OHCA BOARD OFFICERS

Stanley Hupfeld, OHCA Board Chairman

Chairman Hupfeld thanked the board for the privilege of serving as Board Chairman for the last several terms.

MOTION: Chairman Hupfeld moved for approval of Marc Nuttle as 2022 OHCA Board Chairman. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Dell'Osso, Member DeMarco, Member Kennedy

BOARD MEMBERS ABSENT: Member Boyd, Member Nuttle

MOTION: Member Kennedy moved for approval of Alex Yaffe as 2022 OHCA Board Vice-Chairman. The motion was seconded by Member Case

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Curry, Member Dell'Osso, Member DeMarco, Member Kennedy

BOARD MEMBER ABSTAIN: Vice-Chairman Yaffe

BOARD MEMBERS ABSENT: Member Boyd, Member Nuttle

ITEM 13 / DISCUSSION AND POSSIBLE ACTION ON THE ADOPTION OF ROBERT'S RULE OF ORDER AS GOVERNING PARLIAMENTARY PROCEDURE WHERE SUCH DOES NOT CONFLICT WITH THE OPEN MEETING ACT

Kara Smith, General Counsel

Ms. Smith stated that the board can use Robert's Rules of Order to operate the flow of the meeting to the extent it does not conflict with the Open Meeting Act, in which case the Open Meeting Act is going to be controlling. Chairman Hupfeld asked for an example. Ms. Smith stated that tabling, at the previous board meeting, was an improper action. The tabling feature is intended for board members to table an item during the meeting to attend to a more immediate item on the agenda. Once that item has been completed the board would need to return to the item that was tabled. If an item needs to be brought back to a future board meeting, a specific date, time, and place of when that will take place needs to be stated and the process of continuing or reconvening needs to be followed.

Vice Chairman Yaffe asked if there was a downside to adopting this as parliamentary procedure. Ms. Smith stated that it is very strict in how board members communicate during the meeting.

MOTION: Chairman Hupfeld moved for approval to adopt Robert's Rule of Order for OHCA Board Meetings except when they conflict with the Open Meeting Act. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Dell'Osso, Member DeMarco, Member Kennedy

BOARD MEMBERS ABSENT: Member Boyd, Member Nuttle

ITEM 14 / ADJOURNMENT

Stanley Hupfeld, OHCA Board Chairman

MOTION:

Vice-Chairman Yaffe moved for approval for adjournment. The motion was seconded by Member Case.

FOR THE MOTION:

Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Dell'Osso, Member DeMarco, Member Kennedy

BOARD MEMBERS ABSENT:

Member Boyd, Member Nuttle

Meeting adjourned at 4:51 p.m., 11/17/2021

NEXT BOARD MEETING
January 19, 2022
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

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STATE PLAN AMENDMENT RATE COMMITTEE

DEVELOPMENTAL DISABILITIES SERVICES INCREASES SFC

1. IS THIS A RATE CHANGE OR A METHOD CHANGE?

Method Change

2. IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?

Increase

3. PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?

This is a proposal to add a therapeutic leave component to the existing Specialized Foster Care (SFC) waiver service. Currently, SFC providers are very reluctant to access available respite services due to the lack of a retainer payment. If the service recipient is outside of the home for more than 24 hours for respite, a hospitalization or visit with friends or family without the SFC provider, it may become difficult for the provider to retain the placement for that person. The addition of therapeutic leave will provide stability, allow the provider to access respite resources and ensure the service recipient can return to the home. The service is available to child and adult service recipients on the Homeward Bound Waiver and Community Based Waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate structure for approved SFC services is a fixed and uniform rate configuration established through the State Plan Amendment Rate Committee process. The current services, service codes and rates are as follows:

Specialized Foster Care Adult (Maximum)	S5140	\$56.16
Specialized Foster Care Adult (Close)	S5140 U1	\$30.00
Specialized Foster Care Child (Maximum)	S5145	\$56.16
Specialized Foster Care Child (Close)	S5145 U1	\$30.00

5. NEW METHODOLOGY OR RATE STRUCTURE.

The rates for the SFC therapeutic leave will mirror the rates for the corresponding SFC services. The table below indicates the services and per service rate increase proposed:

Specialized Foster Care Adult (Maximum) Therapeutic Leave	S5140 TV	\$56.16
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STATE PLAN AMENDMENT RATE COMMITTEE

Specialized Foster Care Adult (Close) Therapeutic Leave	S5140 U1 TV	\$30.00
Specialized Foster Care Child (Maximum) Therapeutic Leave	S5145 TV	\$56.16
Specialized Foster Care Child (Close) Therapeutic Leave	S5145 U1 TV	\$30.00

6. BUDGET ESTIMATE.

The total SFY23 cost is \$106,142 in total funding, with \$84,394 in federal funds and \$21,748 in state funds. OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

Adding a Specialized Foster Care therapeutic leave component will have a positive impact on access to care as it will enable SFC providers to access needed caregiving breaks and retain the placement when the service recipient is otherwise absent from the home for more than 24 consecutive hours.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.

Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the proposed rate for the SFC therapeutic leave services.

9. EFFECTIVE DATE OF CHANGE.

July 1, 2022, upon approval by CMS



STATE PLAN AMENDMENT RATE COMMITTEE

DEVELOPMENTAL DISABILITIES SERVICES EXTENSIVE RESIDENTIAL SUPPORTS

1. IS THIS A RATE CHANGE OR A METHOD CHANGE?

Rate Change

2. IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?

Increase

3. PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?

DDS proposes to provide a new service, Extensive Residential Supports (ERS), to meet the needs of children and adults whose significant behavioral challenges have historically posed a barrier to their ability to live in a community setting. ERS are provided to members who have significant challenging behavioral needs and require additional supports to enable them to reside successfully in community settings. These services are designed to assist members to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to remain in the community and avoid institutionalization.

ERS provides up to twenty-four (24) hours per day of direct support services, including the provision of more than one staff when the needs of the member indicate additional supports are required. The service includes activities of daily living, assistance with cognitive tasks and provision of services to prevent the member from harming him or herself. In addition, the service also includes, but is not limited to, the following activities:

Behavioral support services to include, but not limited to, the member's physical and verbal aggression, sexual inappropriateness, victimization of others, property destruction, self-harm, threats of suicide and stealing;

Independent living training, which may include personal care, household services and communication skills;

Self-advocacy training and support includes assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing abuse, neglect, mistreatment, and/or exploitation of self, responsibility for one's own actions and participation in all meetings;

Cognitive services, which may include working with the member to better understand and comprehend cause and effect and the correlation between behaviors and consequences. It

STATE PLAN AMENDMENT RATE COMMITTEE

may also take the form of repetitive directions, staying on task, levels of receptive language capabilities and retention of information;

Communication services includes assistance with additional concepts and materials to enhance communication;

Emergency assistance includes safety planning, fire and disaster drills and crisis intervention;

Community access support the abilities and skills necessary to enable the member to access typical activities and functions of community life such as those chosen by the general population, including community education or training and volunteer activities;

A level of supervision necessary to keep the member safe in the home and in the community;

Implementation of recommended follow-up counseling, behavioral or other therapeutic interventions, implementation of physical, occupational or speech therapies or other services delivered under the direction of a licensed or certified professional;

Medical and health care services that are integral to meeting the daily needs of the member such as routine administration of medications or tending to the needs of those who are ill or require attention to their medical needs on an ongoing basis.

ERS including training developed to meet the specific needs of members as well as household management, program supervision and oversight. The latter includes 24-hour availability of response staff to meet schedules or unpredictable needs in a way that promotes maximum dignity and independence and to provide supervision, safety, and security. Staff is available to respond to a crisis to ensure safety, assist members to stabilize and prevent placement disruption.

ERS provides for a therapeutic leave payment to enable the provider to retain personal care services during the time the members is out of his or her home for a period of time in excess of 24 hours without staff due to hospitalization or other absence.

This service is available to members served in the Community Waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

This is a new waiver service. There is no current methodology.



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5. NEW METHODOLOGY OR RATE STRUCTURE.

Eight (8) hours of DLS care at \$160.16 x 3 (to equal 24 hours) = \$480.48

Double HTS staffing on call or on site at 16 hours a day \$16.84 = \$269.44

Difficulty of Care Hourly Rate for DLS staff at \$7.50 = \$180.00

Combined Total Daily Rate \$929.92

6. BUDGET ESTIMATE.

The table below contains the service, service code and proposed rate:

Description	Service code	Proposed rate	Annualized
Extensive Residential Supports	T2033 TG	\$ 929.92	\$3,467,500
Extensive Residential Supports Therapeutic Leave	T2033 TG TV	\$ 929.92	\$1,000,000

The SFY23 cost is projected at \$4,467,500 in total funding, with \$3,552,109 in federal funds and \$915,391 in state funds. Ohs attests it has adequate funding to pay the state share of the projected cost of services.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

This proposed new service will not have a negative impact on access to care.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.

Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the rate for the new Extensive Residential Supports service.

9. EFFECTIVE DATE OF CHANGE.

October 1, 2022, upon approval by CMS



STATE PLAN AMENDMENT RATE COMMITTEE

Remote support with unpaid emergency response staff

1. IS THIS A RATE CHANGE OR A METHOD CHANGE?

Rate Change

2. IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?

Increase

3. PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?

This is a proposal to increase the rate for the remote support service with unpaid emergency response staff. The current rate is deemed insufficient as providers indicate they will not be able to continue to provide the service without an increase. The service is available to adult members on the In-Home Supports for Adults, Homeward Bound Waiver and Community Based Waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate structure for approved remote support services with unpaid emergency response staff is a fixed and uniform rate configuration established through the State Plan Amendment rate committee process. The current service, service code and rate are as follows:

Description	Service code	Current rate
Remote support services with unpaid emergency response staff	T2017 U4	\$1.45 per quarter hour

5. NEW METHODOLOGY OR RATE STRUCTURE.

DDS reviewed data from other states who provide this service as well as input from current providers to make this proposed increase. The table below contains the service, service code and proposed rate:

Description	Service code	Proposed rate	Annualized
Remote support services with unpaid emergency response staff	T2017 U4	\$1.75 per quarter hour	\$17,472



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6. BUDGET ESTIMATE.

The SFY23 annual cost is \$17,472, with \$13,892 in federal funds and \$3,580 in state funds. OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The DDS mission to encourage independence and decrease reliance on in-person staff is enhanced by this proposed increase. This will not have a negative impact on access to care.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.

Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the proposed rate increase for the remote support service with unpaid emergency response staff.

9. EFFECTIVE DATE OF CHANGE.

July 1, 2022, upon approval by CMS

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STATE PLAN AMENDMENT RATE COMMITTEE

DEVELOPMENTAL DISABILITIES SERVICES INCREASES

1. IS THIS A RATE CHANGE OR A METHOD CHANGE?

Rate Change

2. IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?

Increase

3. PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?

OHS is seeking to implement a provider rate increase pursuant to 1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER INSTRUCTIONS AND TECHNICAL GUIDANCE APPENDIX K: EMERGENCY PREPAREDNESS AND RESPONSE.

Oklahoma Human Services (OHS) is seeking a series of 20% retroactive rate increases to support organizations providing services to persons with disabilities. These organizations compete for employees to provide direct care services in a highly competitive labor market. Without this additional support, staffing shortages could result in adverse health and safety outcomes for the individuals served. This increase is being sought to coincide with the federal ARPA program allowing for a 10% reduction in FMAP through March 31, 2022.

The retroactive payments will not exceed 20% of the provider's current payment rate and apply to services paid for the time periods:

October 1, 2021 through December 31, 2021, and;

January 1, 2022 through March 31, 2022.

OHS is seeking to reserve the right to make prorated retroactive rate payments on a monthly basis within the dates of approval to coincide with a permanent rate increase.

OHS is proposing the increase for the following categories of services:

- Adult Day
 - Agency Companion
 - Daily Living Supports
 - Extended Duty Nursing
 - Group Home
-



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- Habilitation Training Specialist
- Homemaker
- Intensive Personal Supports
- Nursing
- Prevocational
- Respite
- Specialized Foster Care
- Supported Employment

Providers have signed an attestation agreement stating 100% of funding received from OHS and or OHCA for the purpose of a retroactive rate adjustment based on services provided beginning January 1, 2021, shall be utilized for the following purposes:

1. Employee wages and benefits
2. Overtime and or hazard pay
3. Recruitment or attendance bonuses
4. Other incentive pays
5. Health and safety costs
6. Other payroll related costs

The services provided by these rates are available to recipients of services paid through the In-Home Supports Waiver for Children, In-Home Supports Waiver for Adults, Homeward Bound Waiver and Community Waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate structure for services provided in the proposed rate changes are fixed and uniform rates established through the State Plan Amendment Rate Committee process. The services, current service codes and rates are as follows:

SERVICE DESCRIPTION	SERVICE CODE	SERVICE UNIT	CURRENT RATE
ADULT DAY CARE	S5100	15 Min	\$2.08
AGENCY COMPANION - CLOSE	S5126 U1	1 Day	\$100.36
AGENCY COMPANION - CLOSE - THERAPEUTIC LEAVE	S5126 U1 TV	1 Day	\$100.36
AGENCY COMPANION - ENHANCED	S5126	1 Day	\$130.52
AGENCY COMPANION - ENHANCED - THERAPEUTIC LEAVE	S5126 TV	1 Day	\$130.52
AGENCY COMPANION - Pervasive Level	S5126 TF	1 Day	\$142.74
AGENCY COMPANION - Pervasive Level - THERAPEUTIC LEAVE	S5126 TF TV	1 Day	\$142.74



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DAILY LIVING SUPPORTS	T2033	1 Day	\$160.16
DAILY LIVING SUPPORTS - Telehealth	T2033 GT	1 Day	\$160.16
DAILY LIVING SUPPORTS - THER LEAVE	T2033 TV	1 Day	\$160.16
ES - CENTER BASED PREVOCAIONAL SVS	T2015 U1	1 Hour	\$5.20
ES - COMMUNITY BASED PREVOCAIONAL SERVICES	T2015 TF	1 Hour	\$10.40
ES - COMMUNITY BASED INDIVIDUAL SERVICES	T2015 U4	1 Hour	\$16.84
ES - EMPLOYMENT SPECIALIST	T2019	15 Min	\$25.12
ES - ENHANCED COMMUNITY BASED PREVOCAIONAL	T2015	1 Hour	\$13.85
ES - JOB COACHING - GROUP OF 4-5	T2019 TF	15 Min	\$13.88
ES - JOB COACHING - GROUP OF 2-3	T2019 HQ	15 Min	\$15.00
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 4-5	T2019 TG	15 Min	\$16.16
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 2-3	T2019 TG-HQ	15 Min	\$17.28
ES - JOB COACHING INDIVIDUAL SERVICES	T2019 U4	15 Min	\$25.00
ES - JOB COACHING INDIVIDUAL SERVICES - Telehealth	T2019 U4 GT	15 Min	\$25.00
ES - JOB STABILIZATION / EXTENDED SERVICES	T2019 U1	15 Min	\$5.76
ES - PRE-VOC. HTS - SUPP. SUPPORTS	T2015 TG	1 Hour	\$13.10
GROUP HOME ALT. LIVING HOME, 4 BED	T1020	1 Day	\$303.68
GROUP HOME COMM. LIVING HOME, 6 BED	T1020	1 Day	\$173.42
GROUP HOME COMM. LIVING HOME, 7 BED	T1020	1 Day	\$148.72
GROUP HOME COMM. LIVING HOME, 8 BED	T1020	1 Day	\$143.78
GROUP HOME COMM. LIVING HOME, 9 BED	T1020	1 Day	\$127.66
GROUP HOME COMM. LIVING HOME, 10 BED	T1020	1 Day	\$125.58
GROUP HOME COMM. LIVING HOME, 11 BED	T1020	1 Day	\$114.14
GROUP HOME COMM. LIVING HOME, 12 BED	T1020	1 Day	\$112.84
GROUP HOME, 6 BED	T1020	1 Day	\$75.40
GROUP HOME, 7 BED	T1020	1 Day	\$64.48
GROUP HOME, 8 BED	T1020	1 Day	\$56.42
GROUP HOME, 9 BED	T1020	1 Day	\$51.48
GROUP HOME, 10 BED	T1020	1 Day	\$47.58
GROUP HOME, 11 BED	T1020	1 Day	\$44.46



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GROUP HOME, 12 BED	T1020	1 Day	\$41.86
HOMEMAKER	S5130	15 Min	\$16.00
HOMEMAKER - EVV	S5130 32	15 Min	\$16.00
HOMEMAKER RESPITE	S5150	15 Min	\$16.00
HOMEMAKER RESPITE - EVV	S5150 32	15 Min	\$16.00
HTS - HABILITATION TRAINING SPECIALIST	T2017	15 Min	\$16.84
HTS - HABILITATION TRAINING SPECIALIST - EVV	T2017 32	15 Min	\$16.84
HTS - HABILITATION TRAINING SPECIALIST - Telehealth	T2017 GT	15 Min	\$16.84
HTS - NO SUPV AGENCY - INDEPENDENT	T2017 U1	15 Min	\$7.60
INTENSIVE PERSONAL SUPPORTS	T2017 TF	15 Min	\$16.84
NURSING EXTENDED DUTY	T1000	15 Min	\$13.52
NURSING INTERMITTENT SKILLED	T1001	1 Visit	\$52.52
NURSING - REGISTERED NURSE	G0299	15 Min	\$15.60
NURSING - LICENSED PRACTICAL NURSE	G0300	15 min	\$14.56
NURSING - LICENSED PRACTICAL NURSE - Telehealth	G0300 GT	15 min	\$14.56
RESPITE - MAXIMUM	S5151	1 Day	\$79.04
RESPITE IN - AGENCY COMPANION - CLOSE	S5151	1 Day	\$123.24
RESPITE IN - AGENCY COMPANION - ENHANCED	S5151	1 Day	\$153.40
RESPITE IN - AGENCY COMPANION - Pervasive	S5151	1 Day	\$165.62
RESPITE IN - GROUP HOME, 6 BED	S5151	1 Day	\$98.70
RESPITE IN - GROUP HOME, 7 BED	S5151	1 Day	\$87.36
RESPITE IN - GROUP HOME, 8 BED	S5151	1 Day	\$79.70
RESPITE IN - GROUP HOME, 9 BED	S5151	1 Day	\$74.36
RESPITE IN - GROUP HOME, 10 BED	S5151	1 Day	\$70.46
RESPITE IN - GROUP HOME, 11 BED	S5151	1 Day	\$67.34
RESPITE IN - GROUP HOME, 12 BED	S5151	1 Day	\$64.74
RESPITE IN - COMMUNITY LIVING HOME, 6 BED	S5151	1 Day	\$196.30
RESPITE IN - COMMUNITY LIVING HOME, 7 BED	S5151	1 Day	\$171.60
RESPITE IN - COMMUNITY LIVING HOME, 8 BED	S5151	1 Day	\$166.66
RESPITE IN - COMMUNITY LIVING HOME, 9 BED	S5151	1 Day	\$150.54
RESPITE IN - COMMUNITY LIVING HOME, 10 BED	S5151	1 Day	\$148.46
RESPITE IN - COMMUNITY LIVING HOME, 11 BED	S5151	1 Day	\$137.02



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RESPIRE IN - COMMUNITY LIVING HOME, 12 BED	S5151	1 Day	\$135.72
RESPIRE, IN OWN HOME-CLOSE	S9125 TF	1 Day	\$28.50
RESPIRE, IN OWN HOME-INTERMITTENT	S9125 U1	1 Day	\$19.00
RESPIRE, IN OWN HOME-MAXIMUM	S9125	1 Day	\$57.04
SPECIALIZED FOSTER CARE ADULT-CLOSE	S5140 U1	1 Day	\$30.00
SPECIALIZED FOSTER CARE ADULT-MAX.	S5140	1 Day	\$56.16
SPECIALIZED FOSTER CARE CHILD-CLOSE	S5145 U1	1 Day	\$30.00
SPECIALIZED FOSTER CARE CHILD-MAX.	S5145	1 Day	\$56.16

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new rates are based on a 20% increase of existing rates.

SERVICE DESCRIPTION	SERVICE CODE	SERVICE UNIT	PROPOSED RATE	TOTAL COST 3 MTHS
ADULT DAY CARE	S5100	15 Min	\$ 2.50	\$160,040.92
AGENCY COMPANION - CLOSE	S5126 U1	1 Day	\$ 120.43	\$42,095.33
AGENCY COMPANION - CLOSE - THERAPEUTIC LEAVE	S5126 U1 TV	1 Day	\$ 120.43	\$171.95
AGENCY COMPANION - ENHANCED	S5126	1 Day	\$ 156.62	\$156,458.64
AGENCY COMPANION - ENHANCED - THERAPEUTIC LEAVE	S5126 TV	1 Day	\$ 156.62	\$1,129.32
AGENCY COMPANION - Pervasive Level	S5126 TF	1 Day	\$ 171.29	\$110,083.55
AGENCY COMPANION - Pervasive Level - THERAPEUTIC LEAVE	S5126 TF TV	1 Day	\$ 171.29	\$1,027.17
DAILY LIVING SUPPORTS	T2033	1 Day	\$ 192.19	\$4,907,150.21
DAILY LIVING SUPPORTS - Telehealth	T2033 GT	1 Day	\$ 192.19	\$ -
DAILY LIVING SUPPORTS - THER LEAVE	T2033 TV	1 Day	\$ 192.19	\$16,526.43
ES - CENTER BASED PREVOCAIONAL SVS	T2015 U1	1 Hour	\$ 6.24	\$179,487.25
ES - COMMUNITY BASED PREVOCAIONAL SERVICES	T2015 TF	1 Hour	\$ 12.48	\$90,663.29
ES - COMMUNITY BASED INDIVIDUAL SERVICES	T2015 U4	1 Hour	\$ 20.21	\$162,960.92
ES - EMPLOYMENT SPECIALIST	T2019	15 Min	\$ 7.54	\$1,016.42
ES - ENHANCED COMMUNITY BASED PREVOCAIONAL	T2015	1 Hour	\$ 16.62	\$23,266.69
ES - JOB COACHING - GROUP OF 4-5	T2019 TF	15 Min	\$ 4.16	\$771,552.43
ES - JOB COACHING - GROUP OF 2-3	T2019 HQ	15 Min	\$ 4.50	\$13,017.88



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ES - ENHANCED JOB COACHING SERVICES - GROUP OF 4-5	T2019 TG	15 Min	\$ 4.85	\$69,899.62
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 2-3	T2019 TG-HQ	15 Min	\$ 5.18	\$6,309.59
ES - JOB COACHING INDIVIDUAL SERVICES	T2019 U4	15 Min	\$ 7.50	\$119,208.63
ES - JOB COACHING INDIVIDUAL SERVICES - Telehealth	T2019 U4 GT	15 Min	\$ 7.50	\$1,469.11
ES - JOB STABILIZATION / EXTENDED SERVICES	T2019 U1	15 Min	\$ 1.73	\$2,395.93
ES - PRE-VOC. HTS - SUPP. SUPPORTS	T2015 TG	1 Hour	\$ 15.72	\$111,820.62
GROUP HOME ALT. LIVING HOME, 4 BED	T1020	1 Day	\$ 364.42	\$411,332.20
GROUP HOME COMM. LIVING HOME, 6 BED	T1020	1 Day	\$ 208.10	\$355,747.06
GROUP HOME COMM. LIVING HOME, 7 BED	T1020	1 Day	\$ 178.46	\$11,727.66
GROUP HOME COMM. LIVING HOME, 8 BED	T1020	1 Day	\$ 172.54	\$ -
GROUP HOME COMM. LIVING HOME, 9 BED	T1020	1 Day	\$ 153.19	\$ -
GROUP HOME COMM. LIVING HOME, 10 BED	T1020	1 Day	\$ 150.70	\$3,932.11
GROUP HOME COMM. LIVING HOME, 11 BED	T1020	1 Day	\$ 136.97	\$7,802.95
GROUP HOME COMM. LIVING HOME, 12 BED	T1020	1 Day	\$ 135.41	\$8,946.59
GROUP HOME, 6 BED	T1020	1 Day	\$ 90.48	\$387,700.31
GROUP HOME, 7 BED	T1020	1 Day	\$ 77.38	\$8,393.52
GROUP HOME, 8 BED	T1020	1 Day	\$ 67.70	\$113.58
GROUP HOME, 9 BED	T1020	1 Day	\$ 61.78	\$ -
GROUP HOME, 10 BED	T1020	1 Day	\$ 57.10	\$13,342.73
GROUP HOME, 11 BED	T1020	1 Day	\$ 53.35	\$6,461.62
GROUP HOME, 12 BED	T1020	1 Day	\$ 50.23	\$22,895.19
HOMEMAKER	S5130	15 Min	\$ 4.80	\$20,052.89
HOMEMAKER - EVV	S5130 32	15 Min	\$ 4.80	\$33,682.23
HOMEMAKER RESPITE	S5150	15 Min	\$ 4.80	\$74,880.10
HOMEMAKER RESPITE - EVV	S5150 32	15 Min	\$ 4.80	\$9,994.71
HTS - HABILITATION TRAINING SPECIALIST	T2017	15 Min	\$ 5.05	\$5,020,392.07
HTS - HABILITATION TRAINING SPECIALIST - EVV	T2017 32	15 Min	\$ 5.05	\$870,282.69
HTS - HABILITATION TRAINING SPECIALIST - Telehealth	T2017 GT	15 Min	\$ 5.05	\$ -
HTS - NO SUPV AGENCY - INDEPENDENT	T2017 U1	15 Min	\$ 2.28	\$ -
INTENSIVE PERSONAL SUPPORTS	T2017 TF	15 Min	\$ 5.05	\$195,429.91



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NURSING EXTENDED DUTY	T1000	15 Min	\$ 8.11	\$151,482.33
NURSING INTERMITTENT SKILLED	T1001	1 Visit	\$ 63.02	\$62,985.41
NURSING - REGISTERED NURSE	G0299	15 Min	\$ 18.72	\$12,391.95
NURSING - LICENSED PRACTICAL NURSE	G0300	15 min	\$ 17.47	\$3,678.98
NURSING - LICENSED PRACTICAL NURSE - Telehealth	G0300 GT	15 min	\$ 17.47	\$37.42
RESPIRE - MAXIMUM	S5151	1 Day	\$ 94.85	\$71.10
RESPIRE IN - AGENCY COMPANION - CLOSE	S5151	1 Day	\$ 147.89	\$52.79
RESPIRE IN - AGENCY COMPANION - ENHANCED	S5151	1 Day	\$ 184.08	\$374.53
RESPIRE IN - AGENCY COMPANION - Pervasive	S5151	1 Day	\$ 198.74	\$468.21
RESPIRE IN - GROUP HOME, 6 BED	S5151	1 Day	\$ 118.44	\$105.69
RESPIRE IN - GROUP HOME, 7 BED	S5151	1 Day	\$ 104.83	\$ -
RESPIRE IN - GROUP HOME, 8 BED	S5151	1 Day	\$ 95.64	\$ -
RESPIRE IN - GROUP HOME, 9 BED	S5151	1 Day	\$ 89.23	\$ -
RESPIRE IN - GROUP HOME, 10 BED	S5151	1 Day	\$ 84.55	\$ -
RESPIRE IN - GROUP HOME, 11 BED	S5151	1 Day	\$ 80.81	\$ -
RESPIRE IN - GROUP HOME, 12 BED	S5151	1 Day	\$ 77.69	\$ -
RESPIRE IN - COMMUNITY LIVING HOME, 6 BED	S5151	1 Day	\$ 235.56	\$ -
RESPIRE IN - COMMUNITY LIVING HOME, 7 BED	S5151	1 Day	\$ 205.92	\$ -
RESPIRE IN - COMMUNITY LIVING HOME, 8 BED	S5151	1 Day	\$ 199.99	\$ -
RESPIRE IN - COMMUNITY LIVING HOME, 9 BED	S5151	1 Day	\$ 180.65	\$ -
RESPIRE IN - COMMUNITY LIVING HOME, 10 BED	S5151	1 Day	\$ 178.15	\$ -
RESPIRE IN - COMMUNITY LIVING HOME, 11 BED	S5151	1 Day	\$ 164.42	\$ -
RESPIRE IN - COMMUNITY LIVING HOME, 12 BED	S5151	1 Day	\$ 162.86	\$ -
RESPIRE, IN OWN HOME-CLOSE	S9125 TF	1 Day	\$ 34.20	\$ -
RESPIRE, IN OWN HOME-INTERMITTENT	S9125 U1	1 Day	\$ 22.80	\$ -
RESPIRE, IN OWN HOME-MAXIMUM	S9125	1 Day	\$ 68.45	\$ -
SPECIALIZED FOSTER CARE ADULT-CLOSE	S5140 U1	1 Day	\$ 36.00	\$ -
SPECIALIZED FOSTER CARE ADULT-MAX.	S5140	1 Day	\$ 67.39	\$90,482.55
SPECIALIZED FOSTER CARE CHILD-CLOSE	S5145 U1	1 Day	\$ 36.00	\$ -
SPECIALIZED FOSTER CARE CHILD-MAX.	S5145	1 Day	\$ 67.39	\$32,424.48



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6. BUDGET ESTIMATE.

The total cost to fund the two retroactive rate increases in SFY22 is \$29,530,834, with \$26,433,050 in federal funds and \$3,097,784 in state funding. OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The rate increase will have a positive impact on access to care.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.

Oklahoma Human Services requests the State Plan Amendment Rate Committee approve two rate increases limited to 20% of claims, paid retroactively, for the periods October 1, 2021 through December 31, 2021 and January 1, 2022 through March 31, 2022.

9. EFFECTIVE DATE OF CHANGE.

April 1, 2022, or upon approval by CMS

STATE PLAN AMENDMENT RATE COMMITTEE

ADvantage Waiver SERVICES Rate Increases

1. IS THIS A RATE CHANGE OR A METHOD CHANGE?

Rate Change

2. IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?

Increase

3. PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?

OHS is seeking to implement a provider rate increase pursuant to 1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER INSTRUCTIONS AND TECHNICAL GUIDANCE APPENDIX K: EMERGENCY PREPAREDNESS AND RESPONSE.

Oklahoma Human Services (OHS) is seeking a series of 20% retroactive rate increases to support organizations providing services to frail elderly and persons with disabilities aged 21 to 64. These organizations compete for employees to provide direct care services in a highly competitive labor market. Without this additional support, staffing shortages could result in adverse health and safety outcomes for the individuals served. This increase is being sought to coincide with the federal ARPA program allowing for a 10% reduction in FMAP through March 31, 2022.

The retroactive payments will not exceed 20% of the provider’s current payment rate and will apply to services paid for the time periods:

October 1, 2021 through December 31, 2021; and,

January 1, 2022 through March 31, 2022.

OHS is seeking to reserve the right to make prorated retroactive rate payments on a monthly basis within the dates of approval to coincide with a permanent rate increase.

OHS is proposing the increase for the following categories of services:

- Case Management / Transitional Case Management Services (Standard and Very Rural)
 - Home Care Services
 - Registered Nurse Skilled Nursing – Home Health Setting
 - Registered Nurse Skilled Nursing – Extended State Plan
 - Licensed Practical Nursing – Home Health Setting
 - Licensed Practical Nursing – Extended State Plan
-

STATE PLAN AMENDMENT RATE COMMITTEE

- Personal Care Services
- Advanced Supportive/Restorative
- In-home Respite (less than 8 hours)
- In-home Extended Respite (8+ hours)
- Adult Day Health Services
 - Adult Day Health
 - Personal Care in Adult Day Health
- Assisted Living Services
 - Assisted Living Standard Tier
 - Assisted Living Intermediate Tier
 - Assisted Living High Tier
- Hospice Services
- Nursing Facility Respite Services

Providers have signed an attestation agreement stating 100% of funding received from OHS and or OHCA for the purpose of a retroactive rate adjustment based on services provided beginning January 1, 2021, shall be utilized for the following purposes:

1. Employee wages and benefits
2. Overtime and or hazard pay
3. Recruitment or attendance bonuses
4. Other incentive pays
5. Health and safety costs
6. Other payroll related costs

The services provided through these rates are available to recipients of the *ADvantage* Waiver.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**

The current rate structure for services provided in the proposed rate changes are of two types:

- Utilizing the Medicaid rate established for state plan services. Services of this type include:
 - Personal Care Services
 - Respite Services
 - Nursing Facility Respite Services
 - Fixed and uniform rates established through the state plan amendment rate committee process. Services of this type include:
-



STATE PLAN AMENDMENT RATE COMMITTEE

- Case Management (Standard and Very Rural)
- Transitional Case Management (Standard and Very Rural)
- Nursing
- Adult Day Health Care
- Advanced Supportive/Restorative Assistance
- Assisted Living Services
- Hospice Services

All services are in 15-minute units except In-Home Extended Respite, Personal Care in Adult Day Health, Assisted Living (all tier levels), Hospice, and Nursing Facility Respite, which are all per-diem services.

The services, current service codes and rates are as follows:

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate	Total Cost for 3 Months
Case Management – Standard	T1016	15 min	\$15.29	\$8,486,286
Case Management – Very Rural	T1016 TN	15 min	\$21.89	\$2,587,114
Transitional Case Management – Standard	T1016 U3	15 min	\$15.29	\$3,456
Transitional Case Management – Very Rural	T1016 TN U3	15 min	\$21.89	\$2,802
Registered Nurse Skilled Nursing – Home Health Setting	G0299	15 min	\$15.60	\$126,903
Registered Nurse Skilled Nursing – Extended State Plan	G0299 TF	15 min	\$15.60	\$0
Licensed Practical Nursing – Home Health Setting	G0300	15 min	\$14.56	\$170,454
Licensed Practical Nursing – Extended State Plan	G0300 TF	15 min	\$14.56	\$116
Personal Care Services	T1019	15 min	\$4.21	\$15,354,785
Advanced/Supportive Restorative Assistance	T1019 TF	15 min	\$4.52	\$179,747
In-home Respite (less than 8 hours)	T1005	15 min	\$4.21	\$29,104
In-home Extended Respite (8+ hours)	S9125	Per day	\$175.55	\$878
Adult Day Health Services	S5100 U1	15 min	\$2.08	\$284,339
Personal Care in Adult Day Health	S5105	Per day	\$8.27	\$1,530
Assisted Living Services – Standard Tier	T2031	Per day	\$48.99	\$441



STATE PLAN AMENDMENT RATE COMMITTEE

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate	Total Cost for 3 Months
Assisted Living Services – Intermediate Tier	T2031 TF	Per day	\$66.11	\$20,424
Assisted Living Services – High Tier	T2031 TG	Per day	\$92.47	\$2,723,827
Hospice Services	S9126	Per day	\$123.80	\$105,435
Nursing Facility Respite Services	120	Per day	\$178.88	\$7,003

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new rates are based on a 20% increase of existing rates.

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate	Proposed Rate	Total Cost for 3 Months
Case Management – Standard	T1016	15 min	\$15.29	\$18.35	\$10,183,544
Case Management – Very Rural	T1016 TN	15 min	\$21.89	\$26.27	\$3,104,537
Transitional Case Management – Standard	T1016 U3	15 min	\$15.29	\$18.35	\$4,147
Transitional Case Management – Very Rural	T1016 TN U3	15 min	\$21.89	\$26.27	\$3,362
Registered Nurse Skilled Nursing – Home Health Setting	G0299	15 min	\$15.60	\$18.72	\$152,284
Registered Nurse Skilled Nursing – Extended State Plan	G0299 TF	15 min	\$15.60	\$18.72	\$0
Licensed Practical Nursing – Home Health Setting	G0300	15 min	\$14.56	\$17.47	\$204,544
Licensed Practical Nursing – Extended State Plan	G0300 TF	15 min	\$14.56	\$17.47	\$140
Personal Care Services	T1019	15 min	\$4.21	\$5.05	\$18,425,742
Advanced/Supportive Restorative Assistance	T1019 TF	15 min	\$4.52	\$5.42	\$215,696
In-home Respite (less than 8 hours)	T1005	15 min	\$4.21	\$5.05	\$34,924
In-home Extended Respite (8+ hours)	S9125	Per day	\$175.55	\$210.66	\$1,053
Adult Day Health Services	S5100 U1	15 min	\$2.08	\$2.50	\$341,207
Personal Care in Adult Day Health	S5105	Per day	\$8.27	\$9.92	\$1,836
Assisted Living Services – Standard Tier	T2031	Per day	\$48.99	\$58.79	\$529
Assisted Living Services – Intermediate Tier	T2031 TF	Per day	\$66.11	\$79.33	\$24,509
Assisted Living Services – High Tier	T2031 TG	Per day	\$92.47	\$110.96	\$3,268,592



STATE PLAN AMENDMENT RATE COMMITTEE

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate	Proposed Rate	Total Cost for 3 Months
Hospice Services	S9126	Per day	\$123.80	\$148.56	\$126,522
Nursing Facility Respite Services	120	Per day	\$178.88	\$214.66	\$8,404

6. BUDGET ESTIMATE.

Oklahoma's FFY22 FMAP of 68.31% has been temporarily increased to 89.51% as a result of the ACA Expansion, FFCRA and ARPA incentives. For each three-month period, the total projected cost is \$30,084,644, with \$26,928,765 in federal funds and \$3,155,879 in state funds. For a one-month period, the total projected cost is \$10,028,215, with \$8,976,255 in federal funds and \$1,051,960 in state funds.

The 20% retroactive temporary rate adjustment results in a total increased cost of \$36,101,572 per three-month period, which is an increase of \$6,016,928 per three-month period over the current base rate. Of this increased amount, \$5,385,752 is Federal funding and \$631,176 is State funding. For a one-month period, the total projected cost of the 20% rate adjustment is \$2,005,643, with \$1,795,251 in federal funds and \$210,392 in state funds.

The total cost to fund the full six-months of the retroactive rate increase is \$12,033,856, with \$10,771,505 in federal funds and \$1,262,351 in state funds.

OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The rate increase will have a positive impact on access to care.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.

Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the two rate increases limited to 20% of claims, paid retroactively for the periods of October 1, 2021 through December 31, 2021, and January 1, 2022 through March 31, 2022, with the option of paying on a monthly basis.

9. EFFECTIVE DATE OF CHANGE.

April 1, 2022, or upon approval by CMS

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**SUBMITTED TO THE C.E.O. AND BOARD ON March 30, 2022
AUTHORITY FOR EXPENDITURE OF FUNDS**

BACKGROUND

Services	Customer Relationship Management (CRM)
Purpose and Scope	Maximus assists OHCA with operations of a Customer Relationship Management solution, including a call center, for its interactions with Members or potential Members in its health care benefit programs, contracted or potential health care providers, allied agencies and organizations and other interested parties.
Mandate	Not Applicable
Procurement Method	Extension
New Contract Term	Date of signature through June 30, 2023.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	\$15,665,584.00
75% Federal Match Percentage(s) within the Total Contract Not-to-Exceed	\$11,621,284.00
50% Federal Match Percentage(s) within the Total Contract Not-to-Exceed	\$4,044,300.00

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the services for Customer Relationship Management System described above from Date of signature through June 30, 2023, for a total not-to-exceed \$15,665,584.00

Additional Information

<p>Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)</p>
<p>Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by \$125,000.00 or more, the contract increase shall require additional Board approval.)</p>
<p>Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)</p>



OKLAHOMA

Health Care Authority

Status of Disaster Relief-related Federal Authorities
Post the Public Health Emergency Expiration
as of
March 22, 2022

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Executive Summary

The Oklahoma Health Care Authority submitted disaster-relief requests to the Centers for Medicare & Medicaid Services (CMS) for a number of flexibilities in response to the COVID-19 public health emergency (PHE). The requests were submitted through various 1135 waiver requests, Title XIX and Title XXI Children's Health Insurance Program (CHIP) disaster-relief state plan amendments (SPAs), as well as Home and Community-Based Services (HCBS) Appendix K requests. OHCA's requests are approved by CMS or authorized by federal legislation and CMS blanket approvals. The State's 1135 waiver requests and disaster-relief SPAs expire upon the termination of the public health emergency (PHE) declaration.

The Families First Coronavirus Response Act (FFCRA) increased FMAP is available for qualifying expenditures that were incurred on or after January 1, 2020 and through the end of the quarter in which the PHE ends. The continuous enrollment requirement in section 6008(b)(3) of the FFCRA prevents states seeking to claim the temporary FMAP increase from terminating eligibility for individuals enrolled in Medicaid as of or after March 18, 2020, through the end of the month in which the PHE ends, even if the individual no longer meets eligibility requirements, unless the person voluntarily disenrolls or is no longer a state resident. The requirements of section 6008 of the FFCRA do not apply to separate CHIPs.

Conditions described in section 6008(b) of the FFCRA can extend beyond the expiration of the COVID-19 PHE declaration, including (in some cases) through the end of the calendar quarter in which the PHE ends (if the state claims the temporary FMAP increase under FFCRA section 6008 in that quarter). However, Disaster Relief State Plan Amendments (DRSPAs) expire on the date the PHE declaration expires. Therefore, states may need to amend their underlying state plans to ensure that they are able to meet the FFCRA section 6008(b) conditions for the entire period during which those conditions apply.

- For example, Oklahoma provides for coverage and/or payment of services required under FFCRA section 6008(b)(4) under a DRSPA, and wants to claim the FFCRA section 6008 temporary FMAP increase in the quarter in which the COVID-19 PHE ends, it will need another SPA in place to effectuate coverage and payment for those services through the end of the quarter in which the COVID-19 PHE ends.

The American Rescue Plan (ARP) mandates that the State provide COVID-19 related countermeasures without cost sharing to populations within the Family Planning and Tuberculosis limited-benefit plans (Optional COVID-19 group) through the expiration of the PHE declaration. No federal financial participation is available for any state expenditures on benefits for this group, including coverage of COVID-19 vaccinations, vaccine administration, testing, and treatment after the PHE ends. Executive Staff should determine if the State wishes to maintain this coverage for the Optional COVID-19 Group beyond the PHE period. If so, a Title XIX SPA will be needed.

The ARP mandates that the State provide COVID-19 related countermeasures without cost sharing to populations with the State's separate CHIP program, Soon-to-be-Sooners (STBS), through the end of the ARP period. Executive Staff should determine if the State wishes to maintain this coverage in its separate CHIP program beyond the ARP period. If so, a Title XXI CHIP SPA will be needed.

When the State makes a decision affecting a beneficiary's eligibility or when ending an authority results in a member's termination, reduction or change in benefits or services, the State must generally provide at least 10-days advance notice of the change and the beneficiary's right to a Medicaid fair hearing or a CHIP review. Fair hearing rights are not triggered when temporary flexibilities end at the conclusion of the PHE, but individuals still have the right to a fair hearing if the Agency's decision was made incorrectly.

Title XIX Disaster-relief Flexibilities that will be MAINTAINED After the PHE , effective one day after the PHE ends

Title XIX Disaster-Relief SPA Requests	Status Post-PHE
<p>Disregard resources or built-up assets that result from any payment made by the federal, state, local, or tribal government to relieve the adverse economic impacts of the COVID-19 pandemic that would have otherwise been part of an individual's liability for his or her institutional services based on application of the post-eligibility treatment-of income (PETI) rules but which became countable resources on or after March 1, 2020 and/or retained through the end of the COVID-related public health emergency for individuals who are 65 years of age or older or are disabled individuals.</p>	<p>OHS is pursuing a temporary Title XIX SPA (effective one day after the PHE ends and ending 12-months after the effective date)</p>
<p>Allow nurse practitioners, clinical nurse specialists, or physician assistants, working in accordance with State law, to order home health services as per the CARES Act.</p>	<p>Approved Permanent Change Effectuated within Title XIX SPA 21-0026 (effective indefinitely)</p>
<p>Allow adults in the Medicaid program access to services (inclusive of crisis intervention services) provided by independently contracted clinical psychologists practicing within state scope of practice.</p>	<p>ODMHSAS is pursuing a permanent Title XIX SPA (effective indefinitely)</p>
<p>The OHCA will extend the current vaccine administration reimbursement methodologies, as per the Oklahoma Medicaid State Plan, to pharmacies for all Advisory Committee on Immunization Practices (ACIP) recommended vaccines</p> <ul style="list-style-type: none"> • After the ARP coverage period, coverage of ACIP-recommended vaccinations without cost sharing will be mandatory for adults enrolled in an ABP 	<p>OHCA is pursuing a permanent Title XIX SPA (effective indefinitely)</p>
<p>Establish a rate increase for private duty nursing (PDN) providers for PDN hours that result in over-time rate of pay for nursing staff.</p> <ul style="list-style-type: none"> • The increase from \$32/hour to \$40/hour is to be applied only for persons with tracheostomies or who are ventilator dependent. 	<p>OHCA is pursuing a permanent Title XIX SPA (effective indefinitely)</p>

Disaster-Related Flexibilities that are ARP-MANDATED TEMPORARY Federal Authority

ARP-Mandated Requests	Status Post PHE
<p>Assurance to CMS for coverage and reimbursement of COVID-related countermeasures for individuals receiving Family Planning or Tuberculosis benefits only (aka Optional COVID-19 group) without cost sharing:</p> <ul style="list-style-type: none"> • vaccine administration, • COVID-19 vaccine counseling for children under the age of 21, • testing services, • testing-related services, and treatments for COVID-19, including, specialized equipment, and therapies (including drugs), and • treatment for conditions that may seriously complicate the treatment of COVID 	<p style="text-align: center;">OHCA is pursuing a TEMPORARY Title XIX ARP SPA (effective 3/11/2021 through the day the PHE ends)</p>
<p>Assurance to CMS for coverage and reimbursement of COVID-related countermeasures for ALL other TXIX individuals without cost sharing:</p> <ul style="list-style-type: none"> • vaccine administration, • COVID-19 vaccine counseling for children under the age of 21, • testing services, • testing-related services, and treatments for COVID-19, including, specialized equipment, and therapies (including drugs), and • treatment for conditions that may seriously complicate the treatment of COVID 	<p style="text-align: center;">OHCA is pursuing a TEMPORARY Title XIX ARP SPA (effective 3/11/2021 through 15 months post-PHE)</p>
<p>Assurance to CMS for coverage and reimbursement of COVID-related countermeasures for all TXXI individuals (including S-CHIP) without cost sharing:</p> <ul style="list-style-type: none"> • vaccine administration, • COVID-19 vaccine counseling for children under the age of 21, • testing services, • testing-related services, and treatments for COVID-19, including, specialized equipment, and therapies (including drugs) and • treatment for conditions that may seriously complicate the treatment of COVID 	<p style="text-align: center;">OHCA is pursuing a TEMPORARY Title XXI ARP SPA (effective 3/11/2021 through 15 months post-PHE)</p>

<p style="text-align: center;">ARP-Mandated Requests</p>	<p style="text-align: center;">Status Post PHE</p>
<p>Assurance to CMS for coverage of COVID-related treatment for individuals receiving Family Planning or Tuberculosis benefits only (aka Optional COVID-19 group) without cost sharing based on COVID-19 diagnoses codes.</p>	<p style="text-align: center;">OHCA is pursuing a TEMPORARY 1115 Demonstration ARP Waiver (effective 3/11/2021 through the day the PHE ends)</p>
<p>Assurance to CMS for coverage of COVID-related countermeasures for all other TXIX individuals without cost sharing:</p> <ul style="list-style-type: none"> • treatments for COVID-19, including, specialized equipment, and therapies (including drugs) and • treatment for conditions that may seriously complicate the treatment of COVID 	<p style="text-align: center;">OHCA is pursuing a TEMPORARY 1115 Demonstration ARP Waiver (effective 3/11/2021 through 15 months post-PHE)</p>

Federal Disaster-Relief Requests TERMINATING with the PHE

1135 Waiver Request

Additional blanket waivers approved by CMS are set forth

**Blanket waivers apply to all applicable providers and do not require a request be sent or that notification be made to CMS.*

Waiver of 42 CFR 431.408(a)(3) in order to conduct all public hearings required for waiver submission virtually rather than in person.

Waiving certain provider enrollment requirements, such as provider enrollment fees, criminal background checks associated with fingerprint-based criminal checks, site visits, screening levels and in-state/territory licensure.

Temporarily suspending the revalidation of all providers who are located in Oklahoma or otherwise directly impacted by the emergency.

Waive the requirement that critical access hospitals limit the number of beds to 25 and that the length of stay be limited to 96 hours.

Suspend the three-day prior hospitalization for coverage of a skilled nursing facility stay for the duration of the emergency.

Waive Emergency Medical Treatment and Labor Act (EMTALA) sanctions for redirection of an individual to receive a focused medical screening examination related to COVID-19 in an alternative location.

Suspend minimum data set submission requirements for clients in non-skilled nursing facilities for 60 days.

Allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA compliant teleconference or video conference team meetings are held.

Postponing member-eligibility renewals that are scheduled to occur during the emergency declaration.

Temporarily delay scheduling Medicaid fair hearings and issuing fair-hearing decisions during the emergency period to allow an additional 120 days to appeal and issue decisions.

Added flexibility to suspend or modify prior authorization requirements for accessing covered state plan and waiver benefits during the emergency period. OHCA will only utilize this option if unable to review and process PAs due to staff shortage or technology failure.

Waive state plan or waiver-imposed utilization controls on covered benefits to the extent such limits cannot be exceeded based on medical necessity in the relevant approved state plan or waiver authority.

Allowing expanded use of telehealth through the end of the declared public health emergency, for most SoonerCare reimbursable services.

Waive pre-admission screening and annual resident review level I and II for 30 days.

Allow durable medical equipment providers to waive replacement requirements, such as the face-to-face requirement, new physician's order, and a renewal medical necessity documentation.

1135 Waiver Request

Additional blanket waivers approved by CMS are set forth

**Blanket waivers apply to all applicable providers and do not require a request be sent or that notification be made to CMS.*

Waiver of face-to-face encounter requirements for reimbursement in 42 CFR 405.2463(a)(B)(3) and 42 CFR 440.90(a) for FQHCs, RHCs, and Tribal 638 Clinics to allow for telephonic services provided by clinic providers for new or established clinic patients. Telephonic services would be reimbursed on a fee-for-service basis and not PPS.

Waiver of requirement for Tribal 638 clinics that services be provided within the clinic four walls except for homeless populations per 42 FR 440.90 to allow for the screening and testing away from patient areas and allow for services to homebound and others. Tribal 638 clinics would be able to bill these visits at the federally established OMB rate methodology. CMS has extended the grace period for states and Tribal facilities to come into compliance with the "Four Walls" requirement under 42 C.F.R. § 440.90 to nine months after the COVID-19 PHE ends

Waiver of the requirement that clinic services must be provided within the four walls of the clinic pursuant to 42 CFR 440.90 to allow for the screening and testing away from patient areas and allow for services to homebound and others. CMS has extended the grace period for states and Tribal facilities to come into compliance with the "Four Walls" requirement under 42 C.F.R. § 440.90 to nine months after the COVID-19 PHE ends

Allow payment for personal care services rendered by legally responsible individuals for the period of the public health emergency.

Flexibility allowing providers to receive payments for services provided to affected SoonerCare members in alternative physical settings, such as mobile testing sites, temporary shelters or facilities. This would include allowing facilities such as NFs, ICF/IIDs, PRTFs and hospitals to be fully reimbursed for services rendered during an emergency evacuation to an unlicensed facility (where an evacuating facility continues to render services). The facility would be responsible for determining how to reimburse the unlicensed facility. This arrangement would only be effective for the duration of the Section 1135 Waiver. However, after the initial 30 days, CMS would require that the unlicensed facility either seek licensure or the evacuating facility would need to seek new placement for the individuals.

Title XIX Disaster Relief SPA REQUESTS

Modify the requirement to submit a SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020.

Waive public notice requirements that would otherwise be applicable to this SPA submission.

Request to notify tribal partners of all SPA changes on or before submission to CMS as well as offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.

Eligibility

Title XIX Disaster Relief SPA REQUESTS

Allow hospitals to make presumptive eligibility (PE) determinations for non-MAGI individuals, including:

- Individuals Eligible for But Not Receiving Cash Assistance, 1902(a)(10)(A)(ii)(I);
- Individuals Eligible for Cash Except Institutionalization, 1902(a)(10)(A)(ii)(IV);
- Optional State Supplemental Beneficiaries, 1902(a)(10)(A)(ii)(XI);
- Individuals in Institutions Eligible under a Special Income Level, aged, blind and disabled individuals, 1902(a)(10)(A)(ii)(V) and 1905(a)(iii), (iv) and (v); and
- Age and Disability-Related Poverty Level, 1902(a)(10)(ii)(X) and 1902(m).

Benefits

Establish coverage of mobile COVID-19 testing sites.

Aligning the Expansion Adult ABP with the previously approved disaster-relief requests to apply newly added and/or adjusted benefits to Alternative Benefit Plans (ABP).

Change the 34-day supply prescription quantity limit to allow for a 90-day supply.

Expand prior authorization for medications by automatic renewal without clinical review, or time/quantity extensions.

Provider Reimbursement

Allow rural/independent Medicaid-enrolled hospitals to request an interim payment.

Establish a supplemental payment based on the cost for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), in a form of a one-time lump sum to eligible nursing facilities serving residents classified by the state as ventilator-dependent.

Allow a temporary supplemental payment for long-term care facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to support increased costs due to COVID-19. The effective date for the supplemental payments will be retroactive to July 1, 2020 and will end on June 30, 2021. If the public health emergency is extended past June 30, 2021 supplemental payments will continue to be made to eligible facilities.

Waive the penalties for possibly preventable readmissions that exceed 100% of the statewide average.

Increase the number of therapeutic leave days in nursing facilities (NFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) from 7 days NF & 60 days ICF-IID to 10 days NF & ICF-IID 70 days.

Waive the provision that payments for therapeutic leave days could not exceed a maximum of 14 consecutive days per absence for ICF/IIDs.

1115 SoonerCare Choice Demonstration Flexibilities

Suspend premium obligations as a requirement for eligibility in the Insure Oklahoma Individual Plan during the emergency period as well as accept, for purposes of eligibility. IO IP members were transitioned to Medicaid Expansion

1915(c) HCBS Disaster-Relief Requests PENDING Post-PHE Status

1915c HCBS Waiver Appendix K Request	Status Post-PHE
Advantage Waiver	
Temporarily modify service scope and coverage, exceeding certain service limitations, adding services, expanding service settings, suspending exception requirements, modifying provider qualifications, modifying licensure requirements, modifying level of care evaluation processes, modifying person-centered service plans, modifying incident reporting requirements, allowing payments for hospitalized services, including retainer payments, and allowing for video conferencing/telehealth opportunities.	Pending LTCSS Expires 6 Months after the PHE Ends
Allow an extension of three months to respond to the Draft Quality Review Report for the Advantage Waiver.	Pending LTCSS Expires 6 Months after the PHE Ends
Update the end date to 1/26/2021.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily increase payment rates for home care services, adult day health services, assisted living services, hospice services, and nursing facility respite services.	Pending LTCSS Expires 6 Months after the PHE Ends
Update the end date to six months after the Public Health Emergency expiration.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily include a retroactive COVID-19 add on payment not to exceed 20% of the provider's current rate during the period beginning October 1, 2020 through December 31, 2020.	Pending LTCSS Expires 6 Months after the PHE Ends
Community Waiver	

1915c HCBS Waiver Appendix K Request	Status Post-PHE
Change to employment training, adult day services, service plans, examination requirements, staffing ratios for case management, and various other changes in response to the Covid-19 emergency.	Pending LTCSS Expires 6 Months after the PHE Ends
Add electronic methods of service delivery to allow service to continue to be provided remotely in the home setting.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily allow for service limits to be exceeded, expanding setting(s) where services may be provided, and increasing payment rates.	Pending LTCSS Expires 6 Months after the PHE Ends
Update the end date to six months after the Public Health Emergency expiration.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily include a retroactive COVID-19 add on payment not to exceed 20% of the provider's current rate during the period beginning October 1, 2020 through December 31, 2020.	Pending LTCSS Expires 6 Months after the PHE Ends
Homeward Bound Waiver	
Change to employment training, adult day services, service plans, examination requirements, staffing ratios for case management, and various other changes in response to the Covid-19 emergency.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily allow provision of Habilitation Training Specialist service to adult members using HIPAA compliant phone or video conferencing in non-residential service settings.	Pending LTCSS Expires 6 Months after the PHE Ends
Add electronic methods of service delivery to allow service to continue to be provided remotely in the home setting.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily allow for service limits to be exceeded, expanding setting(s) where services may be provided, and increasing payment rates.	Pending LTCSS Expires 6 Months after the PHE Ends
Update the end date to six months after the Public Health Emergency expiration.	Pending LTCSS

1915c HCBS Waiver Appendix K Request	Status Post-PHE
	Expires 6 Months after the PHE Ends
Temporarily include a retroactive COVID-19 add on payment not to exceed 20% of the provider's current rate during the period beginning October 1, 2020 through December 31, 2020 .	Pending LTCSS Expires 6 Months after the PHE Ends
In Home Supports Waiver for Adults	
Temporarily extend deadlines, allowing for payment of HTS services, allowing professional providers to utilize telehealth, allowing prescriptions from various health providers to last 24 months, allowing providers to monitor employment sites remotely, and allowing specialized medical supplies and assistive tech to be billed without a referring/ordering physician on the claim.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily allow provision of Habilitation Training Specialist service to adult members using HIPAA compliant phone or video conferencing in non-residential service settings.	Pending LTCSS Expires 6 Months after the PHE Ends
Add electronic methods of service delivery to allow service to continue to be provided remotely in the home setting.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily increase the individual cost limit, expanding setting(s) where services may be provided, and increasing payment rates.	Pending LTCSS Expires 6 Months after the PHE Ends
Update the end date to six months after the Public Health Emergency expiration.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily include a retroactive COVID-19 add on payment not to exceed 20% of the provider's current rate during the period beginning October 1, 2020 through December 31, 2020.	Pending LTCSS Expires 6 Months after the PHE Ends
In Home Supports Waiver for Children	
Temporarily suspend requirements and deadlines pertaining to in-home supports for children.	Pending LTCSS Expires 6 Months after the PHE Ends

1915c HCBS Waiver Appendix K Request	Status Post-PHE
Temporarily allow provision of Habilitation Training Specialist service to adult members using HIPAA compliant phone or video conferencing in non-residential service settings	Pending LTCSS Expires 6 Months after the PHE Ends
Add electronic methods of service delivery to allow service to continue to be provided remotely in the home setting.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily increase the individual cost limit, expanding setting(s) where services may be provided, and increasing payment rates.	Pending LTCSS Expires 6 Months after the PHE Ends
Update the end date to six months after the Public Health Emergency expiration.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily include a retroactive COVID-19 add on payment not to exceed 20% of the provider's current rate during the period beginning October 1, 2020 through December 31, 2020.	Pending LTCSS Expires 6 Months after the PHE Ends
Medically Fragile Waiver	
Allow certified case management and skilled nursing services via telehealth. Temporarily modifying service plan development, allowing for payment of personal care services when a member is in a short-term care facility, and allowing for professional providers to utilize telehealth services.	Pending LTCSS Expires 6 Months after the PHE Ends
Update the end date to 1/26/2021.	Pending LTCSS Expires 6 Months after the PHE Ends
Update the end date to six months after the Public Health Emergency expiration.	Pending LTCSS Expires 6 Months after the PHE Ends
Temporarily include a retroactive COVID-19 add on payment not to exceed 20% of the provider's current rate during the period beginning October 1, 2020, through December 31, 2020.	Pending LTCSS Expires 6 Months after the PHE Ends

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PUBLIC HEALTH EMERGENCY (PHE) ELIGIBILITY RENEWAL



The Families First Coronavirus Response Act (2020) included a “continuous coverage” requirement so individuals would not be at risk of losing health coverage during the PHE.

- States received a 6.2% increase in federal Medicaid matching dollars for maintaining Medicaid coverage for individuals no longer eligible.
- OHCA has paused terminating SoonerCare eligibility.

Exceptions:

- Voluntary disenrollment
- No longer Oklahoma resident
- Death of the member

Federal HHS Secretary Xavier Becerra will announce the end to the PHE. OHCA will then begin the renewal process to determine which members will remain eligible for coverage. OHCA estimates more than 200,000 members will be affected by the PHE ending.

Process for Renewal

The redetermination process will begin the first of the month following the end of the PHE.

- OHCA will alert affected members once Secretary Becerra announces the end of the PHE.
- Those members determined to be eligible will continue to receive SoonerCare benefits.
- Those members determined to be ineligible will be removed from SoonerCare in phases throughout the year using a risk-based approach, focusing on members utilization and critical health needs.
- Based on the phased-out approach, members will receive an initial notification letter before the end of the PHE with their new end date.
- Members will receive an initial notification letter once Secretary Becerra announces the end date of the PHE. Due to the phased out approach by OHCA, members will also receive their specific end date of benefits.
- A third notice will be sent 10 days before the member loses eligibility.



OKLAHOMA
Health Care Authority

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PHARMACY DEPARTMENT OVERVIEW

Terry Cothran, D.Ph.

Senior Pharmacy Director

March 16th, 2022



DRUG PRICE INCREASES IMPACTING MEDICAID SPEND

- Medicaid Drug spend for FY 2019 was \$66.7 billion on outpatient prescription drugs with \$37.1 billion collected in rebates which produced a net spend of \$29.6 billion
- Center for Medicare & Medicaid Services (CMS) projects a Medicaid drug spend increase of 5-6% annually over the next several years
- Medicaid drug spend is increasingly driven by high-cost specialty drugs
 - 2010 -2015 increase from \$4.8 billion to \$9.9 billion (almost doubled)
 - 2019 specialty drugs accounted for 48.5 percent of pharmacy spend from only 1.3 percent of drug utilization
- Pharmaceutical Pipeline
 - Almost 8,000 products in development across all pharmaceutical areas
 - Included are nearly 400 cell and gene therapies (hemophilia A expected \$2-\$3 million)

PHARMACY NUMBERS FOR STATE FISCAL YEAR (SYF) 2021

- Total Drug Claims Paid – 5,417,167
- Members utilizing Pharmacy Services – 489,195
- Average cost per pharmacy claim – \$130.27
- Drug expenditures for adults and children
 - Adults - \$384,928,778 for 153,026 members
 - Children - \$319,367,370 for 356,738 members

DRUG REBATE TOTALS FOR STATE FISCAL YEAR (SYF) 2021

- Pharmacy Overall Spend - \$705,680.56
- Drug Rebate Collections - \$404,889,951.75
- Percentage of Pharmacy spend – 57.4%
- Value-Based Agreement (VBA) Rebates - \$2,141,098.16

DRUG REBATE

- Medicaid Drug Rebate Program (MDRP) is where drug manufacturers pay state Medicaid agencies rebates that are related to the utilization of prescriptions and physician administered drugs in return for coverage of their products
- Bring in around \$400 million in rebates to the agency on an annual basis
- OHCA Pharmacy recoups between 55 – 60% of expenditures through our five drug rebate programs



REBATE PROGRAMS

- **Federal:** drug manufacturers sign agreement with federal government and must pay a rebate based on the utilization of their drug.
- **Supplemental:** Additional rebates drug manufacturers have agreed to pay the state in addition to the federal rebate on the drug.
- **340B:** drug manufacturers provide outpatient drugs to eligible organizations at reduced prices, then drug rebate invoices the eligible organizations for shared savings on the 340B drugs to keep net cost low.
- **Diabetic Supplies:** rebates specific to diabetic supplies
- **Value-Based Agreements (VBA):** a type of supplemental rebate agreement involving value-based purchasing arrangements with drug manufacturers that could produce extra rebates for the state if clinical outcomes are not achieved. Value-Based Agreements can link the payment of a drug to its effectiveness and the outcomes it achieves.
 - Oklahoma was the first state to get this rebate type approved by CMS and initiate a contract with a manufacturer.

PHARMACY OPERATIONS

- Responsible for oversight of the pharmacy benefit for Oklahoma Medicaid, a few examples listed below:
 - Keep the drug files up to date and accurate (30+ thousand active NDC's)
 - System programming/edits for pharmacy claims
 - Implementing and adjusting to the ongoing Public Health Emergency (Covid vaccines, test, treatment, counseling)
 - Collaborate with the Department of Mental Health (DMH) with regards to Medication Assisted Treatment (MAT) and Opioid Treatment Programs (OTP)
 - Medication Therapy Management (MTM) programs
 - Set pricing parameters on select drugs
 - Clinical support for drugs within the agency (ex: medical drug coverage)

PHARMACY MANAGEMENT CONSULTANTS (PMC)

- Responsible for:
 - Pharmacy help desk
 - Prior Authorization (PA) services (24 hour turnaround)
 - Drug Utilization Review (DUR) services
 - Pharmacy lock-in program
 - Prescription Drug Management initiatives
 - Therapy Management programs
 - Academic Detailing
 - Value-Based Agreement (VBA) analysis





Thank you!
Questions & Comments

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Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meeting – November 10, 2021, December 8, 2021, February 9, 2022

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Jakafi® Rezurock™	<ul style="list-style-type: none"> • Graft vs. Host Disease 	<ul style="list-style-type: none"> • \$14,754 per 30 days • \$15,500 per 30 days 	<ul style="list-style-type: none"> • Other options available as first line • Other options available as first line
2	Bylvay™	<ul style="list-style-type: none"> • Progressive Familial Intrahepatic Cholestasis 	<ul style="list-style-type: none"> • \$72,600 per 30 days 	<ul style="list-style-type: none"> • Rare genetic disorder
3	Lupkynis™ Saphnelo™	<ul style="list-style-type: none"> • Lupus Nephritis • Systemic Lupus Erythematosus 	<ul style="list-style-type: none"> • \$142,190 per year • \$59,800 per 4 weeks 	<ul style="list-style-type: none"> • Used in combination with immunosuppressive • Other options available as first line
4	Abecma® Farydak® Pepaxto®	<ul style="list-style-type: none"> • Multiple Myeloma 	<ul style="list-style-type: none"> • \$419,500 per one-time treatment • \$225,320 total for maximum of 16 cycles (48 weeks) • \$19,000 per 28 days 	<ul style="list-style-type: none"> • Not first line, 4 or more prior regimens • Not first line, 2 or more prior regimens • Not first line, 4 or more prior lines of therapy
5	Jemperli®	<ul style="list-style-type: none"> • Endometrial Cancer and dMMR (mismatch repair deficiency) 	<ul style="list-style-type: none"> • \$186,649 per year 	<ul style="list-style-type: none"> • Not first line
6	Opzelura™	<ul style="list-style-type: none"> • Atopic Dermatitis 	<ul style="list-style-type: none"> • \$1,950 per 7 days 	<ul style="list-style-type: none"> • Topical, cheaper options available

Oklahoma Health Care Authority Board Meeting – Drug Summary

7	Livmarli	<ul style="list-style-type: none"> • Cholestatic Pruritis associated with Alagille Syndrome (ALGS) 	<ul style="list-style-type: none"> • \$390,600 per year 	<ul style="list-style-type: none"> • ALGS rare genetic disorder
8	Byooviz™ Susvimo™	<ul style="list-style-type: none"> • Neovascular (wet) Age-related Macular Degeneration 	<ul style="list-style-type: none"> • N/A • \$32,000 per year 	<ul style="list-style-type: none"> • Biosimilar • Not first line
9	Empaveli™	<ul style="list-style-type: none"> • Paroxysmal Nocturnal Hemoglobinuria (PNH) 	<ul style="list-style-type: none"> • \$458,000 per year 	<ul style="list-style-type: none"> • PNH is a rare acquired life-threatening blood disease (1-1.5 persons per million of population)
10	Evkeeza® Leqvio®	<ul style="list-style-type: none"> • Familial Hypercholesterolemia 	<ul style="list-style-type: none"> • \$37,500 per month • \$6,500 per year 	<ul style="list-style-type: none"> • Homozygous familial hypercholesterolemia is a rare life-threatening condition, other options available for treatment • Heterozygous familial hypercholesterolemia genetic; other options available for treatment
11	Myfembree®	<ul style="list-style-type: none"> • Heavy Menstrual Bleeding associated with Uterine Fibroids 	<ul style="list-style-type: none"> • \$12,531 per year 	<ul style="list-style-type: none"> • Other cheaper options available
12	Tyrvaya™	<ul style="list-style-type: none"> • Dry Eye Disease 	<ul style="list-style-type: none"> • \$1,184 per month 	<ul style="list-style-type: none"> • Other cheaper options available

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.

Recommendation 1: Vote to Prior Authorize Jakafi® and Rezurock™

The Drug Utilization Review Board recommends the prior authorization of Jakafi® (Ruxolitinib) and Rezurock™ (Belumosudil) with the following criteria:

Jakafi® (Ruxolitinib) Approval Criteria [Graft-Versus-Host Disease (GVHD) Diagnosis]:

1. Diagnosis of acute or chronic GVHD; and
2. Failure of at least 1 prior line of systemic therapy; and
3. Member must be 12 years of age or older.

Jakafi® (Ruxolitinib) Approval Criteria [Myelofibrosis (MF) Diagnosis]:

1. Diagnosis of MF; and
2. Used in 1 of the following settings:
 - a. Symptomatic lower-risk MF with no response or loss of response to peginterferon alfa-2a or hydroxyurea; or
 - b. Intermediate to high-risk MF; and
3. Member must be 18 years of age or older.

Jakafi® (Ruxolitinib) Approval Criteria [Polycythemia Vera Diagnosis]:

1. Diagnosis of polycythemia vera; and
2. Inadequate response or loss of response to hydroxyurea or peginterferon alfa-2a therapy; and
3. Member must be 18 years of age or older.

Rezurock™ (Belumosudil) Approval Criteria [Graft-Versus-Host Disease (GVHD) Diagnosis]:

1. Diagnosis of chronic GVHD; and
2. Failure of at least 2 prior lines of systemic therapy; and
3. Member must be 12 years of age or older.

Recommendation 2: Vote to Prior Authorize Bylvay™

The Drug Utilization Review Board recommends the prior authorization Bylvay™ (Odevixibat) with the following criteria:

Bylvay™ (Odevixibat) Approval Criteria:

1. An FDA approved indication for the treatment of pruritus in members with progressive familial intrahepatic cholestasis (PFIC); and
 - a. Diagnosis must be confirmed by genetic testing identifying mutations in the *ATP8B1*, *ABCB11*, or *ABCB4* genes; and
2. Member must be 3 months of age or older; and
3. Bylvay™ must be prescribed by a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of PFIC (or an

advanced care practitioner with a supervising physician who is a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of PFIC); and

4. Prescriber must verify member has a history of significant pruritus that is unresponsive to treatment with at least 3 of the following medications, unless contraindicated:
 - a. Ursodeoxycholic acid (UDCA); or
 - b. Cholestyramine; or
 - c. Rifampin; or
 - d. Sertraline; or
 - e. Naltrexone; and
5. Member must have elevated serum bile acid concentration ≥ 100 micromol/L at baseline; and
6. Prescriber must verify member does not have known pathologic variants of the *ABCB11* gene predicting a non-functional or absent bile salt export pump protein (BSEP-3); and
7. Members with a history of liver transplantation will generally not be approved for Bylvay™; and
8. Prescriber must verify surgical intervention (e.g., biliary diversion, liver transplantation) is not currently clinically appropriate for the member; and
9. Prescriber must agree to monitor alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, direct bilirubin, and international normalized ratio (INR) at baseline and during treatment with Bylvay™; and
10. Member's current weight (taken within the past 3 weeks) must be provided on initial and subsequent prior authorization requests in order to authorize the appropriate amount of drug required according to package labeling; and
11. Initial approvals will be for 40mcg/kg/day for a duration of 3 months. After 3 months of treatment, further approval may be granted at the 40mcg/kg/day dose if the prescriber documents the member is responding well to treatment and surgical intervention is still not clinically appropriate; or
12. Dose increases to 80mcg/kg/day (for 3 months) and 120mcg/kg/day (for 3 months) may be approved if there is no improvement in pruritus after 3 months of treatment with the lower dose(s). Further approval may be granted if the prescriber documents the member is responding well to treatment at the current dose and surgical intervention is still not clinically appropriate; and
13. If there is no improvement in pruritus after 3 months of treatment with the maximum 120mcg/kg/day dose, further approval of Bylvay™ will not be granted.

Recommendation 3: Vote to Prior Authorize Lupkynis™ and Saphnelo™

The Drug Utilization Review Board recommends the prior authorization of Lupkynis™ (Voclosporin) and Saphnelo™ (Anifrolumab-fnia) with the following criteria:

Lupkynis™ (Voclosporin) Approval Criteria:

1. An FDA approved indication for the treatment of adults with active lupus nephritis (LN) in combination with a background immunosuppressive therapy regimen; and
 - a. Lupkynis™ must be used in combination with mycophenolate mofetil and low dose oral corticosteroids; and
2. Member must be 18 years of age or older; and
3. Lupkynis™ must be prescribed by a nephrologist, rheumatologist, or other specialist with expertise in the treatment of LN; and
4. Member's current urine protein-to-creatinine ratio (UPCR) must be provided and must be ≥ 1.5 mg/mg; and
5. Member's current estimated glomerular filtration rate (eGFR) must be provided and must be >45 mL/min/1.73m² prior to initiating treatment with Lupkynis™; and
 - a. Prescriber must agree to monitor renal function regularly during treatment with Lupkynis™ and modify the dose as needed in accordance with the Lupkynis™ *Prescribing Information*; and
6. Member's current blood pressure (BP) must be $\leq 165/105$ mmHg prior to initiating treatment with Lupkynis™; and
 - a. Prescriber must agree to monitor BP regularly during treatment with Lupkynis™ and agree to discontinue treatment if BP is $>165/105$ mmHg or member experiences a hypertensive emergency; and
7. Member must not be taking strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin) concomitantly with Lupkynis™; and
8. Prescriber must verify member has been counseled on proper administration of Lupkynis™ including taking it on an empty stomach every 12 hours; and
9. Lupkynis™ will not be approved in combination with biologic therapies or cyclophosphamide; and
10. A quantity limit of 180 capsules per 30 days will apply; and
11. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment as indicated by a reduction in the member's UPCR. If the member does not experience therapeutic benefit by 6 months, discontinuation of Lupkynis™ should be considered; and
12. The safety and efficacy of Lupkynis™ have not been established beyond 1 year of treatment. For continued authorization consideration after 1 year of

treatment, a patient-specific, clinically significant reason why a longer treatment duration is appropriate for the member must be provided.

Saphnelo™ (Anifrolumab-fnia) Approval Criteria:

1. An FDA approved indication for the treatment of adult patients with moderate-to-severe systemic lupus erythematosus (SLE), who are receiving standard therapy; and
2. Member must be 18 years of age or older; and
3. Documented inadequate response to at least 1 of the following medications appropriate to member's specific disease state:
 - a. High-dose oral corticosteroids; or
 - b. Methotrexate; or
 - c. Azathioprine; or
 - d. Mycophenolate; or
 - e. Cyclophosphamide; or
 - f. Hydroxychloroquine/chloroquine; and
4. Member must not have severe active lupus nephritis (LN) or severe active central nervous system lupus; and
5. Saphnelo™ will not be approved for combination use with biologic therapies or cyclophosphamide; and
6. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment.

Recommendation 4: Vote to Prior Authorize Abecma®, Farydak®, and Pepaxto®

The Drug Utilization Review Board recommends the prior authorization of Abecma® (Idecabtagene Vicleucel), Farydak® (Panobinostat), and Pepaxto® (Melphalan Flufenamide) with the following criteria:

Abecma® (Idecabtagene Vicleucel) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM):
 - a. Member has received ≥4 prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor (PI), and an anti-CD38 monoclonal antibody; and
 - i. Induction with or without autologous hematopoietic stem cell transplant and with or without maintenance therapy is considered a single regimen; and
 - ii. Must have undergone ≥2 consecutive cycles of treatment for each regimen unless progressive disease was seen after 1 cycle; and

- b. Member must have measurable disease, including at least 1 of the following:
 - i. Serum M-protein $\geq 0.5\text{g/dL}$; or
 - ii. Urine M-protein $\geq 200\text{mg}/24\text{hr}$; or
 - iii. Serum free light chain (FLC) assay: involved FLC $\geq 10\text{mg/dL}$ (100mg/L); or
 - iv. Bone marrow plasma cells $>30\%$ of total bone marrow cells;
and
- c. Member must not have any central nervous system involvement with multiple myeloma.

Farydak® (Panobinostat) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM); and
2. Used in combination with bortezomib and dexamethasone after 1 or more lines of therapy; or
3. Used in combination with carfilzomib or dexamethasone and lenalidomide after 2 or more lines of therapy (including bortezomib and an immunomodulatory agent).

Pepaxto® (Melphalan Flufenamide) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM); and
2. Member has received at least 4 prior lines of therapy (including being refractory to at least 1 proteasome inhibitor, 1 immunomodulatory agent, and 1 CD-38 directed monoclonal antibody); and
3. Members who are new to treatment with Pepaxto® will generally not be approved.

Recommendation 5: Vote to Prior Authorize Jemperli®

The Drug Utilization Review Board recommends the prior authorization of Jemperli® (Dostarlimab-gxly) with the following criteria:

Jemperli® (Dostarlimab-gxly) Approval Criteria [Endometrial Cancer Diagnosis]:

1. Diagnosis of advanced, recurrent, or metastatic endometrial cancer; and
2. Mismatch repair deficient (dMMR) disease; and
3. Disease has progressed on or following prior treatment with a platinum-containing regimen.

Jemperli® (Dostarlimab-gxly) Approval Criteria [Mismatch Repair Deficient (dMMR) Solid Tumor Diagnosis]:

1. Diagnosis of recurrent or advanced solid tumors that are mismatch repair deficient (dMMR); and

2. Disease has progressed on or following prior treatment; and
3. There are no satisfactory treatment alternatives for the member.

Recommendation 6: Vote to Prior Authorize Opzelura™

The Drug Utilization Review Board recommends the prior authorization of Opzelura™ (Ruxolitinib 1.5% Cream) with the following criteria:

Opzelura™ (Ruxolitinib 1.5% Cream) Approval Criteria:

1. An FDA approved indication for short-term and non-continuous treatment of mild-to-moderate atopic dermatitis; and
2. Member must be 12 years of age or older; and
3. Member must not be immunocompromised; and
4. Member must have a body surface area (BSA) involvement $\leq 20\%$; and
5. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with all of the following therapies (or have a contraindication or documented intolerance):
 - a. One medium potency to very-high potency Tier-I topical corticosteroid (TCS); and
 - b. One topical calcineurin inhibitor (TCI) [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
 - c. Eucrisa® (crisaborole); and
6. Concurrent use with therapeutic biologics, other Janus kinase (JAK) inhibitors, or potent immunosuppressants (e.g., azathioprine, cyclosporine) will not generally be approved; and
7. Prescriber must verify female members are not breastfeeding; and
8. If the member is pregnant or becomes pregnant, prescriber must verify member has been counseled on potential risks of this medication and will report the exposure to the Opzelura™ pregnancy registry; and
9. Approvals will be for a maximum duration of 8 weeks of treatment; and
10. Reauthorization may be considered if member has a recent TCS, TCI, or Eucrisa® trial (or a contraindication or documented intolerance); and
 - a. Additionally, the prescriber must document the member had a positive response to and tolerated previous treatment with Opzelura™; and
11. Subsequent approvals will only be considered once each 90-day period to ensure appropriate short-term and non-continuous utilization.

Recommendation 7: Vote to Prior Authorize Livmarli™

The Drug Utilization Review Board recommends the prior authorization of Livmarli™ (Maralixibat) with the following criteria:

Livmarli™ (Maralixibat) Approval Criteria:

1. An FDA approved indication for the treatment of cholestatic pruritus in members with Alagille Syndrome (ALGS); and
 - a. Diagnosis must be confirmed by genetic testing identifying mutations in the *JAG1* or *NOTCH2* genes; and
2. Member must be 1 year of age or older; and
3. Livmarli™ must be prescribed by a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of ALGS (or an advanced care practitioner with a supervising physician who is a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of ALGS); and
4. Prescriber must verify member has a history of significant pruritus that is unresponsive to treatment with ursodeoxycholic acid (UDCA) and at least 2 of the following, unless contraindicated:
 - a. Ursodeoxycholic acid (UDCA); or
 - a. Cholestyramine; or
 - b. Rifampin; or
 - c. Sertraline; or
 - d. Naltrexone; and
4. Member must have evidence of cholestasis demonstrated by ≥ 1 of the following:
 - a. Total serum bile acid $>3x$ upper limit of normal (ULN) for age; or
 - b. Conjugated bilirubin $>1\text{mg/dL}$; or
 - c. Fat soluble vitamin deficiency otherwise unexplainable; or
 - d. Gamma-glutamyl transferase (GGT) $>3x$ ULN for age; or
 - e. Intractable pruritus explainable only by liver disease; and
5. Members with a history of liver transplantation will not generally be approved for Livmarli™; and
6. Prescriber must verify surgical intervention (e.g., biliary diversion, liver transplantation) is not currently clinically appropriate for the member; and
7. Prescriber must agree to monitor alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, direct bilirubin, and international normalized ratio (INR) at baseline and during treatment with Livmarli™; and
8. Prescriber must verify the member and/or member's caregiver has been counseled on appropriate storage, dosing, and administration of Livmarli™, including the use of a calibrated oral dosing dispenser for accurate measurement; and
9. Member's current weight (taken within the past 3 weeks) must be provided on initial and subsequent prior authorization requests in order to authorize the appropriate amount of drug required according to package labeling; and

10. Initial approvals will be for a duration of 3 months. After 3 months of treatment, further approval may be granted for a duration of 1 year if the prescriber documents the member is responding well to treatment and surgical intervention is still not clinically appropriate.

Recommendation 8: Vote to Prior Authorize Byooviz™ and Susvimo™

The Drug Utilization Review Board recommends the prior authorization of Byooviz™ (Ranibizumab-nuna Intravitreal Injection) and Susvimo™ (Ranibizumab Intravitreal Implant) with the following criteria:

Byooviz™ (Ranibizumab-nuna Intravitreal Injection) Approval Criteria:

1. An FDA approved indication of 1 of the following:
 - a. Neovascular (wet) age-related macular degeneration (AMD); or
 - b. Macular edema following retinal vein occlusion (RVO); or
 - c. Myopic choroidal neovascularization (mCNV); and
2. A patient-specific, clinically significant reason why the member cannot use Lucentis® (ranibizumab intravitreal injection) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Susvimo™ (Ranibizumab Intravitreal Implant) Approval Criteria:

1. An FDA approved indication for the treatment of adults with neovascular (wet) age-related macular degeneration (AMD); and
2. Member must have previously responded to ≥ 2 intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor; and
3. Member must not have ocular or periocular infections or active intraocular inflammation; and
4. Susvimo™ must be prescribed and administered by an ophthalmologist or a physician experienced in vitreoretinal surgery; and
5. Prescriber must verify the member will be monitored for endophthalmitis, rhegmatogenous retinal detachment, implant dislocation, vitreous hemorrhage, conjunctival erosion, conjunctival retraction, and conjunctival blebs; and
6. A patient-specific, clinically significant reason why the member cannot use Lucentis® (ranibizumab intravitreal injection) or other VEGF inhibitor injection products (appropriate to the disease state) must be provided; and
7. Susvimo™ will have a quantity limit of one 100mg/0.1mL single-dose vial every 180 days.

Recommendation 9: Vote to Prior Authorize Empaveli™

The Drug Utilization Review Board recommends the prior authorization of Empaveli™ (Pegcetacoplan) with the following criteria:

Empaveli™ (Pegcetacoplan) Approval Criteria [Paroxysmal Nocturnal Hemoglobinuria (PNH) Diagnosis]:

1. An FDA approved diagnosis of PNH; and
2. Must have an established diagnosis of PNH via international classification of disease (ICD) coding in member's medical claims history; and
3. An age restriction of 18 years and older will apply; and
4. For member self-administration or caregiver administration, the prescriber must verify the member or caregiver has been trained by a health care provider on proper administration and storage of Empaveli™; and
5. Prescriber and pharmacy must be enrolled in the Empaveli™ Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment throughout therapy; and
6. For members switching from Soliris® (eculizumab) to Empaveli™, prescriber must verify the member will continue the current dose of Soliris® for 4 weeks before switching to Empaveli™ as monotherapy; and
7. For members switching from Ultomiris® (ravulizumab-cwvz) to Empaveli™, prescriber must verify that Empaveli™ will be initiated no more than 4 weeks after the last dose of Ultomiris®.

Recommendation 10: Vote to Prior Authorize Evkeeza®

The Drug Utilization Review Board recommends the prior authorization of Evkeeza® (Evinacumab-dgnb) and Leqvio® (Inclisiran) with the following criteria:

Evkeeza® (Evinacumab-dgnb) Approval Criteria:

1. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:
 - a. Documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
 - b. An untreated LDL-cholesterol (LDL-C) >500mg/dL and at least 1 of the following:
 - i. Documented evidence of definite heterozygous familial hypercholesterolemia (HeFH) in both parents; or
 - ii. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; or
2. Member must be 12 years of age or older; and
3. Documented trial of high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy at least 12 weeks in duration; and
4. Members with statin intolerance must meet 1 of the following:

- a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different statins at lower doses (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
5. Documented trial of a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent®, Repatha®) at least 12 weeks in duration; and
 6. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
 7. Female members must not be pregnant and must have a negative pregnancy test prior to therapy initiation. Female members of reproductive potential must be willing to use effective contraception while on therapy and for 5 months after discontinuation of therapy; and
 8. Initial approvals will be for the duration of 6 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of this medication, and compliance will be checked at that time and every 6 months thereafter for continued approval.

Leqvio® (Inclisiran) Approval Criteria:

1. An FDA approved indication of 1 of the following:
 - a. Heterozygous familial hypercholesterolemia (HeFH) as confirmed by 1 of the following:
 - i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
 - ii. Both of the following:
 1. Pre-treatment total cholesterol >290mg/dL or LDL-C >190mg/dL; and
 2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
 - iii. Dutch Lipid Clinic Network Criteria score of >8; or
 - b. Established atherosclerotic cardiovascular disease (ASCVD); and
 - i. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD; and
2. Member must be 18 years of age or older; and
3. Documented trial of all of the following for at least 12 weeks in duration each:
 - a. High dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy; and

- b. Ezetimibe; and
 - c. Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent®, Repatha®); and
4. Members with statin intolerance must meet 1 of the following:
- a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
 - b. An FDA labeled contraindication to all statins; or
 - c. Documented intolerance to at least 2 different statins at lower doses (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
 - d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
5. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
6. Leqvio® must be administered by a health care professional. Approvals will not be granted for self-administration; and
- a. Prior authorization requests must indicate how Leqvio® will be administered (e.g., prescriber, pharmacist, home health care provider); and
 - i. Leqvio® must be shipped to the facility where the member is scheduled to receive treatment; or
 - ii. Prescriber must verify the member has been counseled on the proper storage of Leqvio®; and
7. Initial approvals will be for the duration of 6 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of this medication, and compliance will be checked at that time and every 6 months thereafter for continued approval.

Recommendation 11: Vote to Prior Authorize Myfembree®

The Drug Utilization Review Board recommends the prior authorization of Myfembree® (Relugolix/ Estradiol/Norethindrone) with the following criteria:

Myfembree® (Relugolix/Estradiol/Norethindrone) Approval Criteria:

- 1. An FDA approved diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women; and
- 2. Member must be 18 years of age or older; and
- 3. Member must not have any contraindications to therapy including:
 - a. Osteoporosis; and
 - b. Pregnancy; and
 - c. Female members must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
 - d. Female members of reproductive potential must be willing to use effective non-hormonal contraception during treatment and for at least 1 week after discontinuing treatment; and

- e. Hepatic impairment or disease; and
 - f. Undiagnosed abnormal uterine bleeding; and
 - g. High risk of arterial, venous thrombotic, or thromboembolic disease, including uncontrolled hypertension; and
 - h. Current or history of breast cancer or other hormonally-sensitive malignancies; and
 - i. Known hypersensitivity to ingredients in Myfembree®; and
 - j. Concomitant use with an organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine, gemfibrozil); and
4. Must be prescribed by, or in consultation with, an obstetrician/gynecologist or a specialist with expertise in the treatment of uterine leiomyomas (fibroids); and
 5. A failed trial at least 1 month in duration with nonsteroidal anti-inflammatory drugs (NSAIDs) or a patient-specific, clinically significant reason why the member cannot use NSAIDs must be provided; and
 6. A failed trial at least 3 months in duration of hormonal contraceptives or a patient-specific, clinically significant reason why the member cannot use hormonal contraceptives must be provided; and
 7. For Myfembree®, a patient-specific, clinically significant reason why the member cannot use leuprolide depot formulations available without prior authorization must be provided; and
 8. For Myfembree®, a patient-specific, clinically significant reason (beyond convenience) why the member cannot use Oriahnn® must be provided; and
 9. Quantity limits will apply based on FDA approved dosing:
 - a. For Myfembree®, a quantity limit of 28 tablets per 28 days will apply; and
 10. Lifetime approval duration will be limited to a maximum of 24 months. For members previously approved for Myfembree® or Oriahnn®, a combined cumulative maximum treatment duration of 24 months will apply.

Recommendation 12: Vote to Prior Authorize Tyrvaya™

The Drug Utilization Review Board recommends the prior authorization of Tyrvaya™ (Varenicline Nasal Spray) with the following criteria:

Tyrvaya™ (Varenicline Nasal Spray) Approval Criteria:

1. An FDA approved indication for the treatment of the signs and symptoms of dry eye disease (DED) in members 18 years of age or older; and
2. Prescriber must verify that environmental factors (e.g., humidity, fans) have been addressed; and
3. Member must have trials with at least 3 over-the-counter (OTC) products for at least 3 days in duration (per product) in the last 30 days that failed to relieve signs and symptoms of DED; and

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4. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine 0.05% ophthalmic emulsion) single-use vials, which are available without a prior authorization, must be provided; and
5. A patient-specific, clinically significant reason why the member cannot use all available ophthalmic preparations FDA approved for the treatment of DED must be provided; and
6. A quantity limit of 8.4mL (2 bottles) per 30 days will apply.

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**March Board
Proposed Rules Amendment Summaries**

The following work folders were posted on the Oklahoma Health Care Authority (OHCA) public website for a public comment period.

The following EMERGENCY rules HAVE NOT previously been approved by the Board:

APA WF # 22-01 Non-Emergency Transportation (NEMT) Driver Compliance — The proposed revisions will add language to the Agency's non-emergency transportation (NEMT) policy that assure compliance with recent changes made to federal regulations that any NEMT provider or individual driver will meet prescribed minimum requirements.

Budget Impact: Budget neutral.

Emergency Rule Timeline:

Tribal consultation: November 2, 2021

Public comment period: November 2, 2021 – November 17, 2021

MAC meeting: January 13, 2022

Emergency rule effective date: Contingent upon Governor approval; estimated effective date: March 7, 2022

APA WF # 22-02 Independent Clinical Psychologist Services for Adults — The proposed revisions will update policy to reflect that adults eligible for Medicaid can now access services provided by licensed clinical psychologists who bill independently and are practicing within state scope of practice. Services provided by independently contracted clinical psychologists were previously a State Plan benefit only available to children.

Budget Impact: The proposed rule changes will result in a budget impact of \$1,723,105; with \$361,938 in state share for SFY2022. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

Emergency Rule Timeline:

Tribal consultation: November 2, 2021

Public comment period: January 3, 2022 – January 18, 2022

MAC meeting: January 13, 2022

Emergency rule effective date: Contingent upon Governor's approval; estimated effective date: March 7, 2022

The following permanent rules HAVE previously been approved by the Board and the Governor under EMERGENCY rulemaking. These rules HAVE NOT been revised for PERMANENT rulemaking.

APA WF # 21-01 Reimbursing Federally Qualified Health Centers (FQHCs) for Long-Acting Reversible Contraceptives (LARCs) Outside of the Encounter Rate — The proposed rules add language to clarify that reimbursement for LARCs will be paid outside of the FQHCs encounter rate.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: July 7, 2020

MAC meeting: September 9, 2021

Emergency rule effective date: December 30, 2021

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-04 Diabetes Self-Management Education and Support (DSMES) Services —

The proposed revisions will clarify DSMES provider requirements for registered dietitians, registered nurses, and pharmacists. Revisions will also add other health care providers with certifications as Certified Diabetes Care and Education Specialist (CDCES) or as Board-Certified Advanced Diabetes Management (BC-ADM) as eligible DSMES providers.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: November 3, 2020

Emergency rule effective date: May 1, 2021

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 11, 2021

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: September 2022

APA WF # 21-05A Medicaid Expansion and Durable Medical Equipment — The proposed revisions will expand Medicaid eligibility for individuals defined by 42 C.F.R. § 435.119 (Expansion Adults). Additionally, the proposed revisions will define Expansion Adult benefits, prior authorization requirements, and/or medically necessary criteria. Additional rule revisions will be made to indicate that Expansion Adults will receive prosthetics and orthotics above the current limits to meet federal regulation requirements.

Furthermore, the revisions will comply with the Home Health rule and CURES Act requirements. The federal regulations change medical equipment, appliances, and supplies (formerly called DMEPOS) from an optional benefit to a mandatory benefit that must be provided to all SoonerCare members who meet medical necessity criteria. Additionally, the proposed revisions describe the new coverage criteria, renting versus purchasing equipment, and outlines prior authorization requirements.

The proposed revisions will also update organ transplant requirements, guidelines to reflect current practice, and add a definition for rehabilitation and habilitation.

Finally, revisions will clarify and align policy with current practice and correct grammatical errors.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: To add the new eligibility group, Expansion Adults, the estimated budget impact for SFY2022 will be an increase in the total amount of \$1,339,830,140; \$164,138,054 in state share and \$1,175,692,086 in federal share.

To comply with the home health care final rule, the estimated budget impact for SFY2021 and SFY2022 will be an increase in the total amount of \$2,615,007; \$1,702,631 in federal share and \$912,376 in state share. This budget impact was reflected in the WF# 21-05A emergency rule promulgation documents.

Permanent Rule Timeline:

Tribal consultation: January 7, 2020, and March 2, 2021

MAC meeting: May 14, 2020, and May 13, 2021

Emergency rule effective date: December 21, 2021

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-05B Medicaid Expansion — The proposed rule changes will expand Medicaid eligibility for individuals defined by 42 Code of Federal Regulations § 435.119 who are age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not categorically related to the aged, blind, or disabled. Finally, revisions will clarify and align policy with current practice and correct grammatical errors.

Budget Impact: The budget impact is reflected in APA WF 21-05A, above.

Permanent Rule Timeline:

Tribal consultation: March 2, 2021

MAC meeting: May 13, 2021

Emergency rule effective date: September 7, 2021

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-06 Insure Oklahoma (IO) Individual Plan (IP) and Timely Filing — The proposed revisions reflect that IO IP members and IO Employer-Sponsored Insurance (ESI) members with incomes at or below 138% of the federal poverty level (FPL) will transition to and be provided services by the SoonerCare program under the Expansion Adult option. Additionally, proposed revisions will remove references to the IO IP program as the program is being terminated, add new timely filing requirements for IO ESI subsidy payments, align and clarify policy with current business practice, and correct grammatical errors.

Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. Budget allocation to add the expansion adults eligibility group was approved during promulgation of the emergency rule in July 2021. This budget impact is reflected in APA WF 21-05A, above.

Permanent Rule Timeline:

Tribal consultation: September 01, 2020 and March 2, 2021

MAC meeting: May 13, 2021

Emergency rule effective date: July 01, 2021

Public comment period: December 15, 2021 – January 18, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-07 Payments from Trusts for Clothing Expenses Not Counted as Income — The proposed revisions update Aged, Blind, and Disabled (ABD) countable income policy.

Oklahoma is an SSI-criteria state for determining ABD eligibility. In accordance with amended SSI rules, payments from trusts for the purpose of clothing expenses are not countable as income.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal Consultation: May 4, 2021

MAC meeting: May 13, 2021

Emergency rule effective date: July 19, 2021

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-08 Statewide HIE (OKSHINE) — The proposed policy is necessary to comply with Senate Bill 574 (SB 574) and Oklahoma Statutes Title 63 § 1-133, which create the state designated health information exchange, Oklahoma State Health Information Network and Exchange (OKSHINE). The proposed new policy will outline the program description, definitions, user requirements, and needed certifications of OKSHINE. The implementation of OKSHINE will allow for statewide interoperability and the sharing of Medicaid and public health information.

Budget Impact: The SFY 2022 total cost is \$16,092,660 (\$9,045,165 in federal share and \$7,047,495 in state share). The SFY 2023 total cost is \$6,151,687 (\$799,719 in federal share and \$5,351,968 in state share).

Permanent Rule Timeline:

Tribal Consultation: June 8, 2021

MAC meeting: June 10, 2021

Emergency rule effective date: July 19, 2021

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-09 Supplemental Hospital Offset Payment Program (SHOPP) — The proposed revisions will define “directed payments” as specific payments made by managed care plans to providers under certain circumstances that assist states in furthering the goals and priorities of their Medicaid programs. The measure provides that funds from SHOPP may be used to fund supplemental or directed payments. Additionally, the revisions will modify the assessment calculation methodology from a rate needed to generate an amount up to the sum of certain expenses to a fixed rate. Additionally, the proposed revisions renders the portion of the SHOPP fee attributable to certain expenses null and void if federal matching funds for the program become unavailable. The measure also eliminates the termination date of the program and removes a cap on quarterly transfers of funds. Finally, other revisions include grammar and language cleanup, alignment of the SHOPP rule with current business practice, and changes needed for the funding of expansion adults and services through managed care.

Budget Impact: There is no cost impact. However, the agency estimates that for SFY2022 there will be an increase in state share of \$37,209,936; for SFY2023 there will be an increase in state share of \$89,574,388; and for SFY2024 there will be an increase in state share of \$135,766,567.

Please note, the increase in state share is due to the existing provider tax and all revenue is from hospitals.

Permanent Rule Timeline:

Tribal consultation: June 8, 2021

MAC meeting: June 10, 2021

Emergency rule effective date: July 19, 2021

Public comment period: December 15, 2021 – January 18, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-10 Transitioning Developmental Disabilities Services (DDS) Members back into the Money Follows (MFP)the Person Demonstration — The proposed revisions will add language that allows the DDS to transition members, who have been a resident in a public or private Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or qualified long term care facility, into a community setting through the Living Choice MFP program. The proposed revisions also change the required amount of consecutive time an individual must be in the long term care institution prior to being eligible for transition into the community setting from “at least ninety (90) consecutive days” to sixty (60) consecutive days. Additionally, proposed revision will be removing language that pertained to a pilot program involving the PRTF population, which was not successful and will no longer be implemented. Finally, revisions will remove outdated language to reflect current business practices.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal Consultation: July 6, 2021

MAC meeting: September 9, 2021

Emergency rule effective date: December 21, 2021

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-11 Indian Health Service, Tribal and Urban Indian (I/T/U) Shared Savings Program — The proposed new rules comply with Senate Bill 434 (SB 434), which allows the Oklahoma Health Care Authority (OHCA) to create a shared savings program and shared savings revolving fund with the I/T/U.

Budget Impact: The budget impact is pending. There will be a shift from program to administrative budget. Currently, there is not enough savings to share savings with the tribal clinics. But as the program grows over the next few years the tribes and OHCA could see savings from the program. This may take a year or two to grow to that level.

Permanent Rule Timeline:

Tribal consultation: July 6, 2021

MAC meeting: September 9, 2021

Emergency rule effective date: December 21, 2021

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-12 Purchasing Rule Revisions — The proposed revisions will re-establish Agency-specific rules for purchasing and procurement. Revisions include provisions related to procurement definitions, procurement ethics and prohibited conduct, conflicts of interest, and procurement of goods and services and professional services.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: July 6, 2021

MAC meeting: July 8, 2021

Emergency rule effective date: September 7, 2021

Public comment period: December 15, 2021 – January 18, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-13 Grievance Procedures and Process Rule Revisions — The proposed revisions will revise existing appeals rules to clarify appeals related to the aged, blind, and disabled populations. The proposed rules will also establish appeals rules related to Agency-level appeals for providers and beneficiaries whose initial grievance and/or appeal occurs with an Agency contractor. Additional revisions will clarify the contract award protest process based on whether the OMES Director considers the appeal or assigns the appeal to an administrative law judge.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: July 6, 2021

MAC meeting: July 8, 2021

Emergency rule effective date: December 21, 2021

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-14 Expansion Adults into SoonerCare Choice — The proposed revisions will add expansion adults, as per 42 C.F.R. 435.119, as a group eligible to receive services through the SoonerCare Choice patient-centered medical home (PCMH) service delivery model.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact for SFY 2022 will be an increase in the total amount of \$8,829,743; with \$882,974 in state share.

Permanent Rule Timeline:

Tribal consultation: July 6, 2021

MAC meeting: July 8, 2021

Emergency rule effective date: September 7, 2021

Public comment period: December 15, 2021 – January 18, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-15 Ensuring Access to Medicaid Act — The proposed policy changes will comply with Senate Bill 131 (SB131), otherwise known as the "Ensuring Access to Medicaid Act", by addressing the specific requirements that are outlined throughout the bill. These requirements include, but are not limited to, enrollment and voluntary enrollment into an alternative delivery model, developing specific network adequacy standards, prior authorization requirements, and developing requirements for appeals and hearings.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: July 6, 2021

MAC Meeting: July 8, 2021

Emergency rule effective date: December 21, 2021

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-16 Hospital Presumptive Eligibility (HPE) for Expansion Adults — The proposed policy will add expansion adults to the list of groups eligible to have a presumptive eligibility determination made by a qualified hospital participating in the Hospital Presumptive Eligibility (HPE) program. HPE is a limited period of SoonerCare eligibility for certain eligibility groups that can be determined by a qualified hospital on the basis of preliminary information provided by the applicant while the complete SoonerCare application is being processed.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact for SFY 2022 will be an increase in the total amount of \$841,781; with \$84,178 in state share. The estimated budget impact for SFY 2023 will be an increase in the total amount of \$1,122,375; with \$112,238 in state share.

Permanent Rule Timeline:

Tribal consultation: September 7, 2021

MAC meeting: September 9, 2021

Emergency rule effective date: December 21, 2021

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-19 Appeals to the Chief Executive Officer (CEO)/Administrative Law Judge (ALJ) — The proposed revisions will comply with Oklahoma Senate Bill 207 (SB 207) by revising policies regarding appeals to the Agency's chief executive officer (CEO) pursuant to 63 O.S. §5052(C). The revisions will note that the CEO may only designate an administrative law judge (ALJ) at another state agency, that is established in the State Medicaid Plan, and approved by the Centers for Medicare and Medicaid Services (CMS) to hear and decide a CEO appeal. Further revisions will clarify that telephonic hearings are the preferred format for hearings and a request for an in-person hearing will need to be submitted on the updated LD-4 form. Finally, revisions will add language regarding new appeals that are available to members and providers.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: July 6, 2021

MAC meeting: September 9, 2021

Emergency rule effective date: December 21, 2021

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-20 Alternative Treatments for Pain Management — The proposed policy will establish limited coverage for chiropractor services and physical therapy services as a non-pharmacologic alternative for the treatment of spinal pain in SoonerCare adult members. Furthermore, the proposed policy will define provider participation, medical necessity, as well as coverage and service limitation guidelines. The proposed policy will also state that reimbursement is established within the Oklahoma State Plan. Finally, grammatical and formatting errors will be fixed and references to the new sections will be added.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact for SFY2022 will be an increase in the total amount of \$13,152,504; with \$4,228,530 in state share. The estimated budget impact for SFY2023 will be an increase in the total amount of \$26,305,009; with \$8,457,060 in state share.

Permanent Rule Timeline:

Tribal consultation: July 6, 2021

MAC meeting: September 9, 2021

Emergency rule effective date: January 1, 2022

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-22 Title XXI Dental Revision for Pregnant Women — The proposed revision will amend policy to provide certain dental benefits to pregnant women covered under the Title XXI State Plan. The revision is needed to comply with parity federal regulations which instruct the State to provide services that are medically necessary to the unborn child.

Budget Impact: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact for SFY2022 will be an increase in the total amount of \$185,934; with \$49,626 in state share. The estimated budget impact for SFY2023 will be an increase in the total amount of \$371,869; with \$98,731 in state share.

Permanent Rule Timeline:

Tribal consultation: September 7, 2021

MAC meeting: November 4, 2021

Emergency rule effective date: January 1, 2022

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-26 COFA Migrant Medicaid Extension and Afghan Refugees Eligibility Determinations — The proposed policy establishes rules to update the citizenship/alien status policy to update eligibility determinations related to Compact of Free Association (COFA) migrants from the Republic of the Marshall Islands, the Republic of Palau, and Federated States of Micronesia, as well as Afghan nationals with certain immigration statuses entering the United States, which entitles these individuals to SoonerCare services, provided all other eligibility factors are met. Additionally, language and formatting were updated to align with federal law more closely. The aforementioned proposed rules were promulgated through the Emergency Rule process.

Budget Impact for COFA Migrant Medicaid Extension: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact for SFY 2022 will be an increase in the total amount of \$8,552,972; with \$2,157,059 in state share. The estimated budget impact for SFY 2023 will be an increase in the total amount of \$8,552,972; with \$2,282,788 in state share.

Budget Impact for Afghan Refugee Eligibility Determinations: The previously approved budget impact for the emergency rule is as follows: The estimated budget impact for SFY 2022 will be an increase in the total amount of \$3,841,000; with \$889,082 in state share. The estimated budget impact for SFY 2023 will be an increase in the total amount of \$6,913,800; with \$1,894,554 in state share.

Permanent Rule Timeline:

Tribal consultation: September 7, 2021 and November 2, 2021

MAC meeting: September 7, 2021 and November 4, 2021

Emergency rule effective date: December 21, 2021

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

The following permanent rules HAVE previously been approved by the Board and the Governor under EMERGENCY rulemaking. These rules HAVE been revised for PERMANENT rulemaking.

APA WF # 21-02B OKDHS ADvantage Waiver Services and State Plan Personal Care Services — The proposed revisions will add language to establish guidelines and criteria regarding how an ADvantage member and/or provider are to report critical and non-critical incidents. Additional revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority, which will modify procedures to reflect current business practices. Finally, revisions will correct grammatical errors.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: March 2, 2021 and November 2, 2021

Emergency rule effective date: July 1, 2021

Public comment period: December 15, 2021 – January 18, 2022

MAC meeting: January 13, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: Sept. 2022

APA WF # 21-17 Dental Revisions — Previously approved emergency rule revisions complied with Oklahoma Senate Bill 1046 (SB 1046) by expanding the Oklahoma Health Care Authority's SoonerCare adult dental benefit. The revisions added dental examinations, x-rays, dental cleanings, fluoride, dental fillings, scaling and root planing, as well as dentures and partial dentures as covered services for SoonerCare adult members. Further revisions delineated coverage as well as any applicable service limitation(s). Furthermore, the revisions added language that stated that the new adult dental services are reimbursed pursuant to the current established reimbursement methodology within the Oklahoma State Plan.

Permanent rule revisions will include the revisions made through the emergency rule, and in addition, it will update the certification requirements for primary care physicians to provide fluoride varnish during a well-child health screening. The revisions will also update the timeframe for dental prophylaxis from once every one hundred and eighty-four (184) days to once every six (6) months. Finally, language regarding coverage for periodontal maintenance will be added.

Budget Impact: The estimated budget impact for removing the certification requirements for PCPs to provide fluoride varnish, for SFY2023, will be an increase in the total amount of \$97,682; with \$26,767 state share. The estimated budget impact, for SFY2024, will be an increase in the total amount of \$117,218; with \$38,260 state share.

The estimated budget impact for adding coverage for periodontal maintenance, for SFY2023, will be an increase in the total amount of \$1,288,682; with \$258,104 state share. The estimated budget impact, for SFY2024, will be an increase in the total amount of \$1,718,243; with \$351,469 state share.

Changing the timeframe for dental prophylaxis is budget neutral.

Finally, the previously approved budget impact for the emergency rule to add adult dental services is as follows: The estimated budget impact, for SFY2022, will be an increase in the total amount of \$68,653,438; with \$14,124,398 state share. The estimated budget impact, for SFY2023, will be an increase in the total amount of \$68,653,438; with \$14,867,564 state share.

Permanent Rule Timeline:

Tribal consultation: June 8, 2021 and January 4, 2022

MAC meeting: September 9, 2021 and March 10, 2022

Emergency rule effective date: December 21, 2021

Permanent rule public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

The following PERMANENT rules HAVE NOT previously been approved by the Board:

APA WF # 21-02A OKDHS ADvantage Waiver Services and State Plan Personal Care Services — The proposed revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority. The revisions will provide clarity surrounding eligible provider certification and will modify procedures to reflect current business practices. Finally, revisions will correct formatting and grammatical errors.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: November 2, 2021

Public comment period: December 15, 2021 – January 18, 2022

MAC meeting: January 13, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-27 Policy Reference Clean Up – Timely Filing — The proposed revisions will update a section of policy which describes the process when an individual is determined retroactively eligible for Social Security Disability or Supplemental Security Income (SSI). Current policy states that payment will be made for medical services only if the claim is received within twelve (12) months. The updated policy will refer to two relevant sections of policy: "Timely Filing Limitation" (six months) and "Resolution of Claim Payment" (twelve months if claim initially filed timely).

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: November 2, 2021

Public Comment Period: December 15, 2021 – January 18, 2022

MAC meeting: January 13, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-28 Qualified Medicare Beneficiary Plus (QMBP) Policy Clarification — The proposed revisions clarify policy on how the Agency deems income from an ineligible spouse to an eligible member within the Aged, Blind and Disabled (ABD) eligibility group. The proposed revisions will also clarify that when the eligible member's countable income is over the Social Security Income (SSI) standard, the eligible member must still be evaluated for the Medicare savings program called QMBP.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Effective Date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-29 Partial Hospitalization Program (PHP) Services for Adults — The proposed revisions seek to implement PHP services for individuals ages 21 through 64 with substance use disorder, mental health diagnoses, and/or co-occurring disorders. Currently PHP services is a benefit offered to children under the age of 21, only. The proposed rulemaking will delineate covered service components, provider qualifications, as well as the reimbursement methodology for PHP services provided to adults. Additionally, the proposed rulemaking will reorganize current policy at OAC 317:30-5-241.2 (Psychotherapy, Multi-systemic therapy, PHP, and day treatment programs) into independent sections for clarity and easier retrieval. Moreover, the proposed

revisions will clarify that the clinical team for PHP services for children may include a physician, physician's assistant, or advanced registered nurse practitioner. Finally, the proposed rulemaking will correct minor formatting and grammatical errors.

Budget Impact: The proposed rule changes will result in a total budget impact of \$771,715; with \$160,864 state share for SFY2023 and \$1,394,585; with \$290,701 state share for SFY 2024. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 - March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-30 Eliminate Community Based Extended (CBE) and Community Based Transitional (CBT) Levels of Care — The proposed revisions will eliminate CBE and CBT levels of care. These facilities contract with the OHCA as a type of Psychiatric Residential Treatment Facility (PRTF); however, there is only one contracted CBE facility and zero CBT facilities. The contracted CBE facility will transition to a standard PRTF with the corresponding rate. Other revisions will reorganize policy for clarity and correct grammatical errors.

Budget Impact: The standard PRTF per diem is \$336.57. The current CBE rate is \$319.54, a \$17.03 difference. There were 6,090 paid days for the CBE for SFY 2021. The proposed permanent rule changes will result in a budget impact of \$103,712.70 with \$33,198.4 in state match for SFY2023. For the increased rate, the PRTF will be required to provide 2 additional physician visits per month and 4 additional active treatment hours per week. The State match will be paid by the Department of Mental Health and Substance Abuse Services.

Permanent Rule Timeline:

Tribal consultation: November 2, 2021

Public comment period: December 15, 2021 – January 18, 2022

MAC meeting: January 13, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-31 Applied Behavior Analysis (ABA) Revisions — The proposed revisions will establish new documentation and signature requirements to ensure accuracy and completeness in clinical documentation as well as better individualized treatment plans for members. Additionally, the proposed changes will clarify the conditions under which concurrent billing codes can be used for the treatment of members.

Budget Impact: Budget neutral

Permanent Rule Timeline:

Tribal consultation: November 2, 2021

Public comment period: December 15, 2021 – January 18, 2022

MAC meeting: January 13, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-32 Obstetric (OB) Ultrasound Coverage — The proposed revisions will amend policy to provide coverage of obstetric (OB) ultrasounds in the emergency room (ER) setting when medically necessary and without prior authorization. Finally, the proposed rulemaking will correct minor formatting and grammatical errors.

Budget Impact: The proposed rule changes will result in a total budget impact of \$166,991.75; with \$46,156.52 state share for SFY2023 and \$200,390.10; with \$65,407.33 state share for SFY2024.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 - March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-33 Improve 340B Shared Savings Methodology — The proposed revisions will improve the identification of 340B drugs and non 340B drug purchases. These revisions will require providers to bill the Agency with a procedure code modifier, on outpatient and hospital claims, that will identify a 340B drug from a non 340B drug. Additional revisions will adjust the methodology by which Medicare crossover claims are included on drug rebate invoices to 340B providers.

Budget Impact: The proposed rule changes can potentially result in a reduction to the Agency's overall revenue collections. The potential combined federal and state revenue total loss is \$3,070,428; with \$1,002,188 in state share for SFY2023.

Permanent Rule Timeline:

Tribal consultation: November 2, 2021

Public comment period: December 15, 2021 – January 18, 2022

MAC meeting: January 13, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-34 Reimbursement Methodology for Providers of Certified Community Behavioral Health (CCBH) Services — The proposed revisions update and clarify language regarding covered CCBH services. The revisions also update language regarding reimbursement of CCBH services in alignment with changes to the Oklahoma Medicaid State Plan. These changes included language related to rebasing frequency and scope updates to the Prospective Payment System (PPS) rates. Other revisions will clarify the definition of "Client Assessment Record (CAR)" as a tool recognized by the OHCA and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) in accordance with the prior authorization (PA) manual.

Budget Impact: Budget neutral

Permanent Rule Timeline:

Tribal consultation: September 7, 2021

Public comment period: December 15, 2021 – January 18, 2022

MAC meeting: January 13, 2022

Permanent rule public hearing: January 18, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-35 Lodging and Meals Revisions — The proposed revisions will outline who can request the lodging and meal services and the timeframe that the request must be submitted. Additionally, a clause addressing emergency situations will be added to override the timeframe. The proposed revisions will also outline the information that must be submitted with each request. Further revisions will define meal requirements and what constitutes a meal. Additional revisions will outline how lodging providers and members authorize the member's length of stay. Authorization for length of stay includes having the lodging provider create a document/attestation that lists all the dates that the member has stayed in the facility and requiring the member's review and signature of the document/attestation before he/she/they checks out of the lodging provider's facility. Furthermore, the revisions will specify that it is the responsibility of both, the lodging provider and the member, to ensure that the document/attestation is verified and signed. Additional policy changes will add descriptions and processes for incidental charges and complaints. These changes are necessary to align the policy with current business practices.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-37 Private Duty Nursing (PDN) Revisions — The proposed revisions will update how assessments for PDN services are conducted. Additional revisions will clarify who can sign the PDN treatment plan. Finally, revisions will update grammatical and formatting errors, as well as reorganization of the policy for better clarity and understanding. These revisions are necessary to align the PDN policy with current business practices.

Budget Impact: The proposed rule changes could create a budget savings for the agency. By allowing the OHCA care management nurses to conduct PDN assessments virtually, the nurses' time will be spent on other priorities for our members, instead of traveling.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-38A Developmental Disabilities Services (DDS) Updates for Specialized Foster Care, Agency Companion, Employment Services and Self-Directed Services — The proposed revisions to the DDS policy will add language to clarify that occupation and physical

therapy services can include assistive technology, positioning, and mobility. Additional revisions for speech-language pathology services state that a provider cannot bill or receive reimbursement solely for writing the member's report or recording other documentation. Final revisions will correct formatting and grammatical errors, as well as align policy with current business practices.

Budget Impact: Budget neutral

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: September 2022

APA WF # 21-38B Developmental Disability Services (DDS) Updates for Specialized Foster Care (SFC), Agency Companion, Employment Services and Self-Directed Services — The proposed revisions to the DDS policy will add and provide new guidelines to staff that address provisions for the member's safety including: requirements for member's pets; appropriate supervision as it relates to unrelated habilitation training specialist staffing the home; and outlining actions taken by the provider following an injury to the service recipient. Other revisions will add language to clarify home standard exceptions concerning when adult members will be allowed to share bedrooms; the exception for the division director or designee to allow use of non-traditional bedding for temporary respite; and bedding types that are not usually allowed.

Revisions to the specialized foster care (SFC) section outline substitute supervision criteria. Revisions will also update SFC travel requirements to clarify transportation limits for vacation and what are considered non-covered trips. Other revisions will update the minimum contribution fee from \$250 to \$300 per month for the SFC providers who serve adults. New language will also provide clarification on the case manager's role in reporting issues of concern.

Further revisions will add job coaching as a self-directed service in the In-Home Supports Waiver for Adults, In-Home Supports Waiver for Children, and the Community Waiver when the member lives in a non-residential setting.

Finally, revisions will update and remove outdated language and definitions, remove obsolete references, revoke/combine sections to comply with Executive Order 2020-03, which requires state agencies to reduce unnecessary and outdated rules. Revisions will also correct formatting and grammatical errors, as well as align policy with current business practices.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: September 2022

APA WF # 21-39 Laboratory Services — The proposed revisions will remove outdated language referencing "custom panels particular to the ordering provider" from the list of non-compensable

laboratory services to reflect current business practices. Further revisions will update policy for better ease and understanding.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: September 2022

APA WF # 21-40 Pregnant Women Copayment Language Cleanup — The proposed rule changes will further clarify that no copayment is assessed to pregnant women covered by SoonerCare. The policy changes align Oklahoma's administrative rules regarding copayments for pregnant women and with current business practices.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-41A Outdated/Obsolete Policy Language Cleanup — The proposed rule changes will combine sections of policy to remove the number of sections that are currently in Title 317. These changes are necessary in order to comply with Oklahoma Executive Order 2020-03.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-41B Outdated/Obsolete Policy Language Cleanup — The proposed rule changes will amend language to remove obsolete references. Additional revisions will combine sections of policy to remove the number of sections that are currently in Title 317. These changes are necessary to comply with Oklahoma Executive Order 2020-03.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-42 Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) Visit Limitation Revisions — The proposed revisions will add language that allows for a SoonerCare Choice member, who has chosen an RHC/FQHC as his/her/their Patient Centered Medical Home (PCMH)/Primary Care Provider (PCP), to exceed the four (4) visit limitation.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-43 Opioid Treatment Provider (OTP) Policy Changes — The proposed revisions will update current OTP service and documentation requirements to align with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) provider certification standards. The proposed rulemaking will also correct minor formatting and grammatical errors.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: September 2022

APA WF # 21-45 Referrals for Specialty Services Revisions — The proposed revisions will update retrospective administrative referrals for specialty services within the SoonerCare Choice program. The changes will outline how retrospective administrative referral requests are made and the information that must be provided for the OHCA to process the request. These changes are necessary to align policy with current business practices.

Budget Impact: Budget neutral.

Permanent Rule Timeline:

Tribal consultation: January 4, 2022

Public comment period: February 1, 2022 – March 3, 2022

Permanent rule public hearing: March 8, 2022

MAC meeting: March 10, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION (NEMT)

317:30-5-326. Provider eligibility

~~The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with Section 431.53 of Title 42 of the Code of Federal Regulations. The agency contracts with a broker to provide the most appropriate, and least costly mode of transportation necessary to meet the individual needs of SoonerCare members statewide. Payment for covered services to the broker is made pursuant to the methodology described in the Oklahoma Title XIX State Plan.~~

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with Section 431.53 of Title 42 of the Code of Federal Regulations.

- (1) The agency contracts with a broker to provide the most appropriate, and least costly mode of transportation necessary to meet the individual needs of SoonerCare members statewide.
- (2) All SoonerRide contracted providers must meet the standards and requirements outlined in the Oklahoma Medicaid State Plan, the SoonerRide provider manual and contract, as well as all applicable federal and state laws/regulations.
- (3) Payment for covered services to the broker is made pursuant to the methodology described in the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 25. PSYCHOLOGISTS

317:30-5-275. Eligible providers

(a) Licensed Psychologist must be licensed to practice in the state in which services are provided. Payment is made for compensable services to psychologists licensed in the state in which ~~face-to~~
~~face~~face-to-face services are delivered.

(b) Psychologists employed in State and Federal ~~Agencies~~agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider.

(c) Services provided by practitioners, who have completed education requirements to begin an internship or a post-doctoral fellowship in an accredited clinical psychology academic training program and are under current board approved supervision toward licensure, are eligible for reimbursement. Each supervising psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA).

(d) For those licensure candidates who are actively and regularly receiving board approved supervision, or extended supervision by a fully licensed clinician and if the board's supervision requirement is met but the individual is not yet licensed, each supervising psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA).

(e) In order for services provided by clinical psychology interns completing required internships, post-doctoral fellows completing required supervision for licensure to be reimbursed, the following conditions must be met:

(1) The licensed practitioner billing SoonerCare must have a letter on file covering the dates of services of the internship or ~~post-doctoral~~post-doctoral fellowship;

(2) The psychology intern or post-doctoral fellow must be under the direct supervision of the licensed psychologist who is responsible for the member's care;

(3) The licensed psychologist responsible for the member's care must:

(A) ~~staff~~Staff the member's case with the intern or fellow,

(B) ~~actively~~Actively direct the services;

(C) ~~be~~Be available to the intern or fellow for in-person consultation while they are providing services;

(D) ~~agree~~Agree with the current plan for the member; and

(E) ~~confirm~~Confirm that the service provided by the intern or fellow was appropriate;
and.

(4) The member's medical record must show that the requirements for reimbursement were met and the licensed psychologist responsible for the member's care has reviewed, countersigned, and dated the notes in the medical record at least every week so that it is documented that the licensed psychologist is responsible for the member's care.

317:30-5-276. Coverage by category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 ~~CFR~~Code of Federal Regulations 431.10.

~~(b) **Adults.** Coverage for adults by a psychologist is limited to Bio-Psycho-Social Assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.~~

~~(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.~~

~~(2) For bariatric preoperative assessments, issues to address include, but are not limited to: Depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.~~

~~(e)~~**(b) Children.** Coverage for children includes the following services:

(1) Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one (1) PDIE is allowable per provider per member. If there has been a break in service over a six (6) month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is

considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the psychologist. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one (1) of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of a ~~SoonerCare eligible child~~ the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six (6) patients for children four years of age up to the age of 18. Groups ~~18-20 year olds~~ can include up to eight (8) individuals for members 18-20 years of age. Group therapy must be provided for the benefit of a ~~SoonerCare eligible child~~ the member four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of three), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the

date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Health and Behavior codes - behavioral health services are available only to chronically and severely medically ill ~~children~~ members.

(7) Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.

(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. A maximum of twelve (12) ~~12~~-sessions/units of therapy and testing services per day per provider are allowed. A maximum of thirty five (35) ~~35~~ hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four (4) week average. ~~Case Management services are considered an integral component of the behavioral health services listed above.~~

~~(9) A child who is being treated in an acute psychiatric inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only.~~

(9) A child may receive psychological testing and evaluation services as separately reimbursable services.

(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or ~~psychological testing~~ unless allowed by the OHCA or its designated agent.

(c) **Adults.** Coverage for adults is the same as for children. For group therapy, groups can include up to eight individuals for adult members 18 years of age and older.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services ~~for the intellectually disabled program~~ program for people with intellectual and developmental disabilities must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.1. Provision of other health services outside of the Health Center core services

(a) If the Center chooses to provide other Oklahoma Medicaid State Plan covered health services which are not included in the Health Center core service definition in OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment, and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the ~~PPS~~Prospective Payment System settlement methodology in OAC 317:30-5-664.12.

(b) Other medically necessary health services that will be reimbursed at the ~~FFS~~fee-for-service rate include, but are not limited to:

- (1) Dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;
- (2) Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);
- (3) Clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);
- (4) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);
- (5) Durable medical equipment (refer to OAC 317:30-5-210);
- (6) Transportation by ambulance (refer to OAC 317:30-5-335);
- (7) Prescribed drugs (refer to OAC 317:30-5-70);
- (8) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
- (9) Specialized laboratory services furnished away from the clinic;
- (10) Psychosocial rehabilitation services (refer to OAC 317:30-5-241.3);
- (11) Behavioral health related case management services (refer to OAC 317:30-5-241.6); and
- (12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).
- (13) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084).
- (14) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately).

317:30-5-664.5. Federally Qualified Health Center (FQHC) encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30. Excluded from the definition of reimbursable encounter core services are:

- (1) Services provided by an independently ~~CLIA~~Clinical Laboratory Improvement Amendments certified and enrolled laboratory;
- (2) Radiology services including nuclear medicine and diagnostic ultrasound services;

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate ~~CPT~~Current Procedural Terminology code. A visit for "lab test only" is not considered a Center encounter;

(4) ~~Durable medical equipment or medical supplies~~Medical supplies, equipment, and appliances not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under ~~SoonerCare~~;

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service;

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;

(9) ~~SoonerPlan~~ family planning services;

(10) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately);

~~(10)~~(11) Optometry and podiatric services other than for dual eligible for Part B of Medicare; ~~and~~

(12) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084); and

~~(11)~~(13) Other services that are not defined in this rule or the Oklahoma Medicaid State Plan.

(b) In addition, the following limitations and requirements apply to services provided by ~~Health Centers~~FQHCs:

(1) Physician services are not covered in a hospital; ~~and~~

(2) Behavioral health case management and psychosocial rehabilitation services are limited to ~~Health Centers~~FQHCs enrolled under the provider requirements in OAC 317:30-5-240 and contracted with OHCA as an outpatient behavioral health agency.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-761. Eligible providers

ADvantage Program ~~ADvantage Administration (AA)~~ certifies ADvantage Program service providers, except pharmacy providers, ~~must be certified by the ADvantage Program ADvantage Administration (AA) and must they~~ have a current signed SoonerCare (Medicaid) contract on file with the Oklahoma Health Care Authority (OHCA), the State Medicaid agency.

(1) The provider programmatic-certification process ~~must verify~~ verifies the provider meets licensure, certification, and training standards as specified in the waiver document ~~and agrees to ADvantage Program Conditions of Participation. Providers~~ All providers, except nursing facility (NF) respite; medical equipment and supplies; and environmental modification providers, must obtain programmatic-certification to be ADvantage program certified.

(2) The provider financial-certification process ~~must verify that~~ verifies the provider uses sound business management practices and has a financially-stable business. All providers, except for ~~nursing facility (NF)~~ NF respite; medical equipment and supplies; and environmental modification providers, ~~must~~ will obtain financial certification to be ADvantage program certified.

(3) At minimum, provider financial certification is re-evaluated annually.

~~(3)~~ (4) Providers may fail to gain or may lose ADvantage program certification due to failure to meet programmatic or financial standards.

~~(4) At a minimum, provider financial certification is reevaluated annually.~~ (5) All provider service types must agree to the Conditions of Provider Participation and Service Standards.

~~(5) The Oklahoma Department of Human Services (DHS) Aging Services (AS) evaluates adult day health and home delivered meal providers for compliance with ADvantage programmatic certification requirements. When an adult day health or home delivered meal provider does not have a contract with AS, the provider must obtain programmatic certification to be ADvantage Program certified. Providers of medical equipment and supplies, environmental modification, personal emergency response systems, hospice, Consumer Directed Personal Assistance Services and Supports (CD-PASS), and NF respite services do not have a programmatic evaluation after the initial certification.~~

~~(6) DHS AS~~ The Oklahoma Human Services (OKDHS) Community Living, Aging and Protective Services (CAP) does not authorize the member's CD-PASS services provider to also have an active power of attorney of afor the member to be the member's CD-PASS services provider.

~~(7) DHS AS~~ OKDHS CAP may authorize a member's legally-responsible spouse or legal guardian to be SoonerCare (Medicaid) reimbursed, per 1915(c) ADvantage Program as a personal care, service provider. Authorization for a spouse or legal guardian as a provider requires the criteria in (A) through (D) of this paragraph and monitoring provisions to be met.

(A) Authorization for a spouse or legal guardian to be ~~thea member's~~ the member's care provider ~~for a member~~ may occur only when the member is offered a choice of providers ~~provider choice~~ and documentation demonstrates:

- (i) ~~no~~ No provider included on the Certified Agency Report (CAR) or in the member's service area, has available staffing; ~~This is as evidenced by supportive documentation, which~~ Documentation also affirms ~~no provider within the members service area can staff and~~ all area providers attempt to employ staff to serve; or
- (ii) ~~the~~ The member's needs are so complex that unless the spouse or legal guardian provides the care, the member's risk level would increase; and
- (iii) ~~it~~ It is mentally or physically detrimental for someone other than the spouse or legal guardian to provide care. This is evidenced by ~~the~~ documentation from a qualified clinician or medical provider, such as a physician or licensed psychologist.

(B) The service ~~must~~:

- (i) ~~meet the~~ Meets service or support definition of a service/support as outlined in the federally-approved waiver document;
- (ii) ~~be~~ Is necessary to avoid institutionalization;
- (iii) ~~be~~ Is a service/support service or support specified in the person-centered service plan;
- (iv) ~~be~~ Is provided by a person who meets the provider qualifications and training standards specified in the waiver for that service;
- (v) ~~be~~ Is paid at a rate that does not exceed ~~that which would otherwise be~~ what is paid to a provider of a similar service and does not exceed ~~what is allowed by OHCA~~ allows for the payment of personal care or personal assistance services; ~~an~~ payment; and
- (vi) ~~not be~~ Is not an activity the spouse or legal guardian would ordinarily perform or is responsible to perform.

(C) The spouse or legal guardian service provider complies with:

- (i) ~~providing~~ Providing no more than forty (40) service hours of services in a ~~seven-day (7-day)~~ seven (7) day period;
- (ii) ~~planned~~ Planned work schedules that ~~must be~~ are available in advance for the member's case manager, and variations to the schedule ~~must be~~ are noted and supplied to the case manager two (2) weeks in advance unless the change is due to an emergency;
- (iii) ~~maintaining~~ Maintaining and submitting time sheets and other required documentation for hours paid; and
- (iv) ~~the~~ The person-centered service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the State is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The AA monitors, through quarterly documentation ~~submitted by~~ the case manager, submits, the continued appropriateness of the policy exception that allows the spouse or legal guardian to serve as the member's paid caregiver.

(8) ~~Providers of durable~~ Durable medical equipment and supplies ~~must~~ providers comply with Oklahoma Administrative Code 317:30-5-210(2) regarding delivery ~~proof of delivery~~ for items shipped to the member's residence.

(9) ~~DHS ASO~~ KDHS CAP periodically performs a programmatic audit of: ~~adult day health, assisted living, case management, home care (providers of skilled nursing, personal care, in-home respite, and advanced supportive/restorative assistance and therapy services) and CD-PASS providers. When due to a programmatic audit, a provider~~ Plan of Correction (POC) is

~~required, the AA may stop new cases and referrals to the provider until the (POC) is approved, implemented, and follow-up review occurs. Depending on the nature and severity of problems discovered during a programmatic audit and at the discretion of the DHS AS, members determined to be at risk for health or safety may be transferred from a provider requiring a POC to another provider.~~

~~(A) Adult day health;~~

~~(B) Assisted living;~~

~~(C) Case Management;~~

~~(D) Home care:~~

~~(i) Skilled nursing;~~

~~(ii) Personal care;~~

~~(iii) In-home respite; and~~

~~(iv) Advanced supportive or restorative assistance; and~~

~~(v) Therapy services; and~~

~~(E) CD-PASS providers.~~

(10) When, due to a programmatic audit, a provider plan of correction (POC) is required, the AA may stop new cases and referrals to the provider until the POC is approved, implemented, and a follow-up review occurs. Depending on the nature and severity of problems discovered during a programmatic audit (and at OKDHS CAP discretion), members determined to be at risk for health or safety may be transferred from a provider requiring a POC to another provider.

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

SUBCHAPTER 15. STATE PLAN PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to QMBP, SLMB, Qualified Medicare Beneficiary Plus (QMBP), Specified Low-Income Medicare Beneficiary (SLMB), and other SoonerCare services and eligibility

~~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 individuals with intellectual disabilities (refer to OAC 317:35-9), persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9), Home and Community Based Waiver Services for the Intellectually Disabled (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ADvantage program (refer to OAC 317:35-17), and Personal Care services (refer to this subchapter). Personal Care provides services in the member's own home. Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. Another application is not required. 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 Plus (QMBP) or Specified Low Income Medicare Beneficiary (SLMB) are met. Another application for QMBP or SLMB benefits is not required.~~

~~(a) Long-term medical care for the categorically needy includes:~~

- ~~(1) Care in a nursing facility, per Oklahoma Administrative Code (OAC) 317:35-19;~~
- ~~(2) Public and private intermediate care facility for individuals with intellectual disabilities (ICF/IID), per OAC 317:35-9;~~
- ~~(3) Persons age sixty-five (65) years or older in mental health hospitals, per OAC 317:35-9;~~
- ~~(4) Home and Community-Based Waiver Services for the Intellectually Disabled, per OAC 317:35-9;~~
- ~~(5) Home and Community-Based Waiver Services for the ADvantage program, per OAC 317:35-17; and~~
- ~~(6) State Plan Personal Care services, per OAC 317:35-15.~~

~~(b) State Plan Personal Care provides services in the member's own home. Any time an individual is certified as eligible for long-term care SoonerCare coverage, the member is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind, or disabled individual is determined eligible for long-term care, a separate determination is made to check if the member meets eligibility conditions as a QMBP or an SLMB. Another application for QMBP or SLMB benefits is not required.~~

317:35-15-2. State Plan Personal careCare (SPPC) services

~~(a) Personal careSPPC services is assistance to an individualassist a member in carrying out Activities of Daily Living (ADLs) or in carrying out Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs to prevent, SPPC services prevent or minimize physical health regression or deterioration. Personal care service requiresSPPC services require a skilled nursing assessment to: of need, development of a care plan to meet identified personal care needs, care plan oversight, and periodic re-assessment and updating, of the care plan, when necessary. Personal care services do not include technical services, such as suctioning,~~

~~tracheal care, gastrostomy tube feeding or care, specialized feeding due to choking risk, application of compression stockings, bladder catheterization, colostomy irrigation, wound care, application of prescription lotions or topical ointments, range of motion exercises, or the operation of equipment of a technical nature, such as a patient lift or oxygen equipment.~~

- (1) Assess a member's needs;
- (2) Develop a care plan to meet the member's identified personal care needs;
- (3) Manage care plan oversight; and
- (4) Periodically reassess and update the care plan when necessary.

(b) SPPC services do not include technical services, such as:

- (1) Suctioning;
- (2) Tracheal care;
- (3) Gastrostomy-tube feeding or care;
- (4) Specialized feeding due to choking risk;
- (5) Applying compression stockings;
- (6) Bladder catheterization;
- (7) Colostomy irrigation;
- (8) Wound care;
- (9) Applying prescription lotions or topical ointments;
- (10) Range of motion exercises; or
- (11) Operating equipment of technical nature, such as a patient lift or oxygen equipment.

~~(b)(c) Personal care~~SPPC members may receive services in limited types of living arrangements. ~~The specific living arrangements are set forth below, as per (1) through (5) of this subsection.~~

~~(1) Personal care~~SPPC members are not eligible to receive services while residing in an institutional setting including, but not limited to, ~~licensed facilities, such as a hospital, nursing facility, licensed residential care facility or licensed assisted living facility, or in an unlicensed institutional living arrangement, such as a room and board home or facility. Personal care may not be approved when the client lives in the personal care assistant's home except with the approval of Oklahoma Department of Human Services (DHS) Aging Services.~~

(A) Licensed facilities, such as a:

- (i) Hospital;
- (ii) Nursing facility;
- (iii) Licensed residential care facility; or
- (iv) Licensed assisted living facility; or

(B) In an unlicensed institutional living arrangement, such as a room and board home or facility.

(2) SPPC is not approved when the member lives in the personal care assistant's (PCA) or the individual personal care assistant's (IPCA) home, except with Oklahoma Human Services (OKDHS) Medicaid Services Unit approval.

~~(2) Additional living arrangements in which members~~(3) Members may receive ~~personal care services are~~SPPC services in the member's own home, apartment, or a family member's or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit including a bathroom and food ~~storage/preparation~~storage and preparation amenities in addition to ~~bedroom/living~~bedroom and living space.

~~(3)(4) For personal care~~SPPC members who are full-time students, a dormitory room qualifies as an allowable living arrangement ~~in which to receive personal care services for the period~~

~~during which the member is a student.~~ SPPC services.

~~(4)(5) With prior OKDHS Health Care Management Nurse III approval of the DHS area nurse, personal care~~ SPPC services may be provided in an educational or employment setting to assist the member to achieve vocational goals identified in the care plan.

~~(e)(d) Personal care services may be provided by an individual employed by the member referred to as an individual personal care assistant (IPCA) or by a personal care assistant (PCA) A member may employ an IPCA to provide SPPC services. An IPCA may provide SPPC services when he or she is employed by a home care agency, provided the home care agency is certified to provide personal care services and contracted with the Oklahoma Health Care Authority (OHCA) to provide personal care~~ SPPC services. Before providing SPPC services, DHS must determine an OKDHS determines whether the IPCA to be is qualified to provide personal care services and the IPCA is not identified as formal/informal formal or informal support for member before they can provide services. Persons eligible to serve as either IPCAs or PCAs must:

- ~~(1) be~~ Are at least ~~18~~ eighteen (18) years of age;
- ~~(2) have~~ Have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;
- ~~(3) not be~~ Are not included in the ~~DHS~~ OKDHS Community Services Worker Registry;
- ~~(4) not be~~ Are not convicted of a crime ~~or and do not have any~~ and do not have any a criminal background history or registry listings that prohibit employment per ~~O.S. Title 63, Section 1-1950.1; Title 63 of the Oklahoma Statutes Section 1-1944 through 1-948;~~ O.S. Title 63, Section 1-1944 through 1-948;
- ~~(5) demonstrate~~ Demonstrate the ability to understand and carry out assigned tasks;
- ~~(6) not be~~ Are not a legally responsible family member, ~~such as a spouse, legal guardian, or parent of a minor child of the member being served, such as a spouse, legal guardian, or a minor child's parent exceptions may be made for a legal guardian to provide services only with prior approval from DHS Aging Services;~~ such as a spouse, legal guardian, or a minor child's parent exceptions may be made for a legal guardian to provide services only with prior approval from DHS Aging Services;
- ~~(7) have~~ Have a verifiable work history ~~and/or~~ or personal references, and verifiable identification; and
- ~~(8) meet~~ Meet any additional requirements outlined in the contract and certification requirements with OHCA.

~~(d)(e) Eligibility for Personal Care~~ SPPC services eligibility is contingent on an individual member requiring one (1) or more of the services offered at least monthly that include including personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet ADL or IADL assessed needs.

317:35-15-3. Application for State Plan Personal Care (SPPC) services

(a) **Requests for Personal Care, SPPC services.** ~~A request for Personal Care is made to the local OKDHS office or Advantage Administration (AA). The SPPC application process initiates when an online application is completed for SPPC services. A written financial application is not required for an individual applicant who has an active SoonerCare case. A financial application for Personal Care SPPC services is initiated when there is no active SoonerCare case. The Medicaid application is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf. All financial eligibility conditions of financial eligibility must be verified and documented in the case record. When current available information already available in the local office establishes eligibility, the 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 his or her guardian, or a person acting on the applicant's behalf, such as an~~

authorized representative or power-of-attorney, ~~must sign~~ signs the application form.

(b) ~~Date of application.~~ Application date. The application date is when the benefits request is received and entered into the electronic system by OKDHS. Exceptions can occur when OKDHS has contracts with certain providers who accept and obtain applications and appropriate documentation. Once the documentation, for the SoonerCare eligibility determination, has been obtained, the contracted provider will forward the application and all applicable documentation to either the OKDHS county office or the Medicaid Services Unit-ADvantage Administration.

(1) The date of applications is:

(A) the date the applicant or someone acting on his/her behalf signs the application in the county office;

~~(B) the date the application is stamped into the county office when the application is initiated outside the county office; or~~

~~(C) the date when the request for SoonerCare is made orally and the financial application form is signed later.~~

~~(2) An exception to paragraph (1) of this subsection would occur when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contract provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for SoonerCare eligibility determination. The application date is the date the applicant signed the application form for the provider.~~

(c) Eligibility status. Financial and medical eligibility ~~must be~~ established before services can be initiated.

317:35-15-4. Determination of State Plan Personal Care (SPPC) services medical eligibility for Personal Care determination

(a) Eligibility. The Oklahoma Department of Human Services ~~(DHS)~~ (OKDHS) ~~area nurse~~ Health Care Management Nurse (HCMN) III determines medical eligibility for ~~personal care~~ SPPC services based on the Uniform Comprehensive Assessment Tool (UCAT) ~~Part III~~ and the determination that the member has unmet care needs that require personal care ~~services~~ assistance. ~~Personal care~~ SPPC services are initiated to support the regular care provided in the member's home. ~~Personal care~~ SPPC services are not intended to take the place of regular care, ~~and~~ general maintenance tasks, or meal preparation ~~shared or done for one another~~ provided by natural supports, such as spouses or other adults who live in the same household. Additionally, ~~personal care~~ SPPC services are not furnished when they principally benefit the family unit. To be eligible for ~~personal care~~ SPPC services, the ~~individual must~~ applicant:

(1) ~~have~~ Has adequate informal supports ~~consisting of~~. This means there is adult supervision that is present or available to contribute to care; or decision-making ability, as documented on the UCAT ~~Part III~~, ~~to~~. To remain in his or her home without risk to his or her health, safety, and well-being, the ~~individual~~ applicant:

(A) ~~must have~~ Has the decision-making ability to respond appropriately to situations that jeopardize his or her health and safety, ~~or~~ has available supports that compensate for his or her lack of ability as documented on the UCAT ~~Part III~~; or

(B) ~~who has his or her~~ Has his or her decision-making ability, ~~but~~ lacks the physical capacity to respond appropriately to situations that jeopardize health and safety, ~~and was informed by the DHS nurse~~ an OKDHS HCMN I or II informed him or her of potential risks and consequences, may be eligible of remaining in the home.

(2) ~~require a plan of care involving the planning and administration of services delivered under~~

~~the supervision of professional personnel;~~ Requires a care plan for planning and administering services delivered under a professional personnel's supervision;

(3) ~~have~~ Has a physical impairment or combination of physical and mental impairments as documented on the UCAT ~~Part III~~. An ~~individual applicant~~ who poses a threat to ~~self~~ himself or ~~herself~~ or others, as supported by professional or credible documentation ~~or other credible documentation~~, may not be approved for ~~Personal Care~~ SPPC services. An individual who is actively psychotic or believed to be in danger of potential harm to ~~self~~ himself or ~~herself~~ or others may not be approved for ~~personal care services~~;

(4) ~~not have members of the household or~~ Does not have household members or persons who routinely visit the household who, as supported by professional or credible documentation ~~or other credible documentation~~, pose a threat of harm or injury to the ~~individual applicant~~ or other household visitors;

(5) ~~lack~~ Lacks the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) ~~require~~ Requires assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(b) **Definitions.** The following words and terms, when used in this subsection, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "**Activities of Daily Living**" (ADL) means ~~activities of daily living are~~ activities that reflect the applicant's or member's ability to perform self-care tasks essential for sustaining health and safety, such as:

(A) ~~bathing;~~ Bathing;

(B) ~~eating;~~ Eating;

(C) ~~dressng;~~ Dressing;

(D) ~~grooming;~~ Grooming;

(E) ~~transferring includes~~ Transferring, including activities such as getting in and out of a tub or moving from bed to chair;

(F) ~~mobility;~~ Mobility;

(G) ~~toileting;~~ Toileting; and

(H) ~~bowel/bladder~~ Bowel or bladder control.

(2) "**ADLs score of three (3) or greater**" means the applicant or member cannot do at least one (1) ADL at all or needs some help with two (2) or more ADLs.

(3) "**Consumer Applicant or Member support very low-need**" means the applicant's or member's UCAT ~~Part III~~ Consumer Support score is zero (0), which this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal sources are sufficient for the applicant's or member's present need level ~~of member-need~~ in most functional areas.

(4) "**Consumer Applicant or Member support low-need**" means the member's UCAT ~~Part III~~ Consumer Support score is five (5), which this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the support from formal and informal sources are nearly sufficient for the applicant's or member's present need level ~~of member-need~~ in most functional areas. The applicant or member, family, or informal supports are meeting most needs typically expected of family or household members to share or do for one another, such as general household maintenance. There is little risk of institutional placement with loss of current supports.

(5) "**Consumer Applicant or Member support moderate-need**" means the UCAT ~~Part III~~ Consumer applicant or member score is fifteen (15), which this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal support is available, but overall, it is

inadequate, changing, fragile, or otherwise problematic. The applicant or member requires additional assistance that usually includes personal care assistance with one (1) or more ADLs not available through Medicare, the Veterans Administration, or other federal entitlement programs. ~~Support provided by informal caregivers is of questionable reliability due to one (1) or more of the following:~~ Informal caregiver support is considered questionable or unreliable due to one (1) or more criteria in (A) through (D) of this paragraph:

- (A) ~~care~~ Care or support is required continuously with no relief or backup available;
- (B) ~~informal~~ Informal support lacks continuity due to conflicting responsibilities such as work or child care;
- (C) ~~care or support is provided by persons~~ Persons with advanced age or disability; ~~or provide care; or~~
- (D) ~~institutional~~ Institutional placement can reasonably be expected with any loss of existing support.

(6) ~~"Consumer~~ **Applicant or Member support high need**" means the ~~member's UCAT Part III Consumer~~ applicant or member score is twenty-five (25) ~~which~~ this indicates, in the UCAT ~~Part III~~ assessor's clinical judgment, the formal and informal supports are not sufficient as there is very little or no support available to meet at the applicant's or member's high degree of ~~member~~ need.

(7) ~~"Community services worker"~~ **Services Worker**" means any non-licensed health professional employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities.

(8) **Community Services Worker Registry**" means ~~an~~ an OKDHS established registry established by the ~~DHS,~~ OKDHS per Section (§) 1025.1 of Title 56 of the Oklahoma Statutes (O.S.) ~~to list~~ listing community services workers ~~against whom~~ who have a final investigative finding of abuse, neglect, or exploitation, per 43A O.S. § 10-103, involving a frail elderly, ~~person, disabled person(s), or person(s) with developmental or other~~ disabilities was made by ~~DHS~~ OKDHS or an administrative law judge; ~~and amended in 2002, to include the listing of~~ SoonerCare (Medicaid) personal care assistants (PCAs) providing personal care services.

(9) ~~"Instrumental activities of daily living (IADL)"~~ **Activities of Daily Living (IADL)**" means those daily activities that reflect the applicant or member's ability to perform household chores and tasks within the community essential for sustaining health and safety, such as:

- (A) ~~shopping;~~ Shopping;
- (B) ~~cooking;~~ Cooking;
- (C) ~~cleaning;~~ Cleaning;
- (D) ~~managing~~ Managing money;
- (E) ~~using~~ Using a phone;
- (F) ~~doing~~ Doing laundry;
- (G) ~~taking~~ Taking medication; and
- (H) ~~accessing~~ Accessing transportation.

(10) **IADLs score is at least six (6)**" means the applicant or member needs some help with at least three (3) IADLs or cannot do two (2) IADLs at all.

(11) **IADLs score of eight (8) or greater**" means the applicant or member needs some help with at least four (4) IADLs or the member cannot do two (2) IADLs at all and needs some help with one (1) or more other IADLs.

(12) **MSQ**" means the ~~mental status questionnaire;~~ Mental Status Questionnaire.

(13) "**MSQ moderate risk range**" means a total weighted-score of seven (7) to eleven (11) that indicates an orientation-memory-concentration impairment or memory impairment.

(14) "**Nutrition moderate risk**" means ~~the~~ a total weighted UCAT ~~Part III~~ Nutrition score is eight (8) or ~~more~~ greater that indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

(15) "**Social resources Resource score is eight (8) or more**" means the applicant or member lives alone, ~~or~~ has no informal support when he or she is sick, ~~or~~ needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for ~~personal care~~ SPPC.** ~~The medical eligibility minimum criteria for ~~personal care~~ SPPC services are the minimum UCAT ~~Part III~~ score criteria that ~~an applicant or member must meet~~ meets for medical eligibility for ~~personal care~~ and are:~~

(1) ADLs score is five (5) or greater; or has an IADLs score of eight (8) or greater; or Nutrition score is (8) or greater; or the MSQ score is seven (7) or greater; or the ADLs score is three (3) and IADLs score is at least six (6); and

(2) ~~Consumer~~ Applicant or Member Support score is fifteen (15) or more; or ~~Consumer~~ Applicant or Member Support score is five (5) and the Social Resources score is eight (8) or ~~more~~ greater.

(d) **Medical eligibility determination.** ~~Medical~~ OKDHS HCMN III determines medical eligibility for ~~personal care~~ SPPC services is determined by the DHS. The medical decision for ~~personal care~~ is made by the DHS area nurse utilizing the UCAT ~~Part III~~.

(1) ~~Categorical relationship must be established for SPPC services financial eligibility determination of eligibility for personal care. When categorical relationship to Aid to the Disabled was not established but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1. The licensed health care professional cannot be in a medical facility internship, residency, or fellowship program or in the full time employment of the Veterans Administration, United States Public Health Service, or other agency. The DHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA) definition. A follow up is required by the DHS county worker with (SSA) to ensure the SSA disability decision is also the LOCEU decision.~~

(A) When categorical relationship to Aid to the Disabled is not established, but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination.

(B) When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1.

(C) The licensed health care professional cannot be in a medical facility internship, residency, or fellowship program or in the full-time employment of the Veterans Administration, United States Public Health Service, or other agency.

(D) The OKDHS county worker submits the information to the Level of Care Evaluation

Unit (LOCEU) to request a medical eligibility determination for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA) definition. The OKDHS county worker is required to conduct a follow-up with SSA to ensure the SSA disability decision is also the LOCEU decision.

(2) ~~Approved contract agencies or the ADvantage Administration (AA) may complete UCAT Part I for intake and screening and forward the form to the county office.~~ the electronic application. This alerts the social services specialist (SSS) of application date.

(3) ~~Upon receipt of the referral, DHS county staff may initiate the UCAT, Part I.~~ referral receipt, OKDHS SSS starts the financial eligibility determination.

(4) ~~The DHS nurse~~ OKDHS HCMN I or II is responsible for completing the UCAT ~~Part III~~ assessment visit within ~~ten business~~ (10 business) ten (10) business days of the personal care ~~referral~~ application for the applicant who is SoonerCare eligible at the time of the request. The ~~DHS nurse~~ OKDHS HCMN I or II completes the assessment visit within ~~twenty business~~ (20 business) twenty (20) business days of the referral for the applicant not determined SoonerCare eligible at the time of the request. When the ~~UCAT Part I~~ application indicates the request is from an individual who resides at home and an immediate response is required to ensure the applicant's health and safety of the person, to prevent an emergency situation, or to avoid institutional placement, the UCAT ~~Part III~~ assessment visit has top-scheduling priority.

(5) During the assessment visit, the ~~DHS nurse~~ OKDHS HCMN I or II completes the UCAT ~~Part III~~ and reviews rights to privacy, fair hearing, provider choice, and the pre-service acknowledgement agreement with the member. The DHS nurse informs OKDHS HCMN I or II gives the applicant of information about medical eligibility criteria and provides information about DHS OKDHS long-term care service options. ~~The DHS nurse~~ OKDHS HCMN I or II documents if the member wants to be considered for nursing facility level of care services or if the member is applying for a specific service program on the UCAT-Part III. When, based on the information obtained during the assessment, the ~~DHS nurse~~ OKDHS HCMN I or II determines if the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services (~~APS~~) or Child Protective Services, as applicable. The referral is documented on the UCAT-~~Part III~~.

(A) When SPPC services are not sufficient to meet the applicant's or member's needs cannot be met by personal care services alone, the DHS nurse informs the applicant of the OKDHS HCMN I or II provides information about other community long-term care service options. The DHS nurse OKDHS HCMN I or II assists ~~the applicant~~ in accessing service options ~~selected by the applicant or member selects~~ in addition to, or in place of, ~~Personal Care~~ SPPC services.

(B) When multiple household members are applying for SoonerCare ~~personal care~~ SPPC services, the UCAT ~~Part III~~ assessment is done for all the household members at the same time.

(C) ~~The DHS nurse informs~~ OKDHS HCMN I or II provides the applicant of the or member with information about the qualified agencies in his or her local area that provide services and obtains the applicant's or member's primary and secondary choice of agencies. agency choice. When the applicant or family declines to choose a primary personal care service agency, the ~~DHS nurse selects an agency from a list of all available agencies, using a round-robin rotation system.~~ is used for agency selection. The ~~DHS nurse~~ OKDHS HCMN I or II documents the selected personal care provider agency's name of the selected personal care provider agency.

(6) The ~~DHS nurse~~OKDHS HCMN I or II completes the UCAT ~~Part III~~in the electronic system and sends it to the DHS area nurse forOKDHS HCMN III makes the medical eligibility determination. ~~Personal care~~SPPC service eligibility is established on the date medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) When the time length of time from the initial assessment to the date of service eligibility determination exceeds ~~ninety calendar (90 calendar)~~ninety (90) calendar days, a new UCAT ~~Part III~~ and assessment ~~visit~~ is required.

(B) The ~~DHS area nurse~~OKDHS HCMN III assigns a medical certification period of not more than thirty-six (36) months for persons eighteen (18) years of age and older or not more than twelve (12) months for persons younger than eighteen (18) years of age. The service plan period ~~under the Service Authorization Model (SAM)~~ is for a period of twelve (12) months ~~and is provided by the DHS nurse.~~

(7) The ~~DHS area nurse~~ notifies the ~~DHS county worker~~SSS is notified via Electronic Data Entry and Retrieval System (ELDERS) the electronic system of the personal care certification. ~~The authorization line is open via automation from ELDERS.~~

(8) Upon ~~establishment of personal care~~establishing SPPC certification, the ~~DHS nurse~~ ~~contacts~~OKDHS HCMN I or II notifies the applicant's or member's preferred provider agency, or when necessary, the secondary provider agency or the provider agency selected by the round robin rotation system. Within ~~one business (1 business)~~one (1) business day of provider agency acceptance, the ~~DHS nurse forwards~~OKDHS HCMN I or II submits the ~~referral information via electronic system~~ to the provider agency for SAM plan development. Refer to OAC 317:35-15-8(a).

(9) Following the ~~SAM packet~~provider agency's SPPC plan development, and within ~~three business (3 business)~~three (3) business days of receipt of ~~the packet~~ from the provider agency, the ~~DHS nurse~~OKDHS HCMN I or II reviews the documentation to ensure agreement with the plan. Once agreement is established, the ~~packet~~plan is authorized ~~by the designee~~ or submitted to the ~~area nurse~~OKDHS HCMN III for review.

(10) Within ~~ten business (10 business)~~ten (10) business days of the SPPC plan receipt of the ~~SAM case~~ from the ~~DHS nurse~~, the ~~DHS area nurse~~OKDHS HCMN I or II, the OKDHS HCMN III authorizes or denies the SAM plan units. If the ~~SAM case~~plan fails to meet standards for authorization, ~~the case~~ it is returned to the ~~DHS nurse~~OKDHS HCMN I or II for further justification.

(11) Within ~~one business (1 business)~~one (1) business day of knowledge of the authorization, the ~~DHS nurse forwards~~OKDHS HCMN I or II submits the service plan authorization to the provider agency: via electronic system.

317:35-15-5. General financial eligibility requirements for State Plan Personal Care

Financial eligibility for ~~Personal Care~~SPPC is determined using the rules on income and resources according to the eligibility group ~~to which the individual member is related to.~~ Income and resources are evaluated on a monthly basis for all ~~individuals members~~ requesting payment for ~~Personal Care~~SPPC who are categorically related to ~~ABD; Aged, Blind, or Disabled (ABD);~~ maximum countable monthly income and resource standards for individuals related to ABD are found on ~~OKDHS~~Oklahoma Human Services (OKDHS) form 08AX001E (Appendix C-1), Schedule VI (~~QMBP program standards~~). Qualified Medicare Beneficiary Plus program standards.

317:35-15-6. Determining financial eligibility of categorically needy individuals

Financial eligibility for ~~Personal Care~~State Plan Personal Care (SPPC) services for categorically needy individuals is determined as follows:

- (1) **Financial eligibility for MAGIModified Adjusted Gross Income (MAGI) eligibility groups.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for ~~MAGI~~eligibility groups.
- (2) **Financial ~~eligibility~~/categorically~~eligibility~~ or categorically related to ABD-Aged, Blind, and Disabled.** In determining income and resources for the ~~individual~~member related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income ~~must be~~is less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule VI (~~QMBP~~standard)-Qualified Medicare Beneficiary Plus standard. If an ~~individual and a member~~ and his or her spouse cease to live together for reasons other than institutionalization or receipt of the ~~ADvantage waiver or HCBW/MR~~a Home and Community Based Waiver, ADvantage or Developmental Disabilities services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts ~~which are actually contributed~~to the spouse after the mutual consideration has ended are considered.
- (3) **Determining financial eligibility for State Plan Personal Care-(SPPC).** For individuals determined categorically needy for ~~Personal Care~~,SPPC, the member will not pay a vendor payment for ~~Personal Care~~SPPC services.

317:35-15-7. Certification for State Plan Personal Care

- (a) **State Plan Personal Care (SPPC) certification period.** The first month of the ~~Personal Care~~SPPC certification period ~~must be~~is the first month the member ~~was~~is determined financially and medically eligible for ~~Personal Care~~,SPPC ~~both financially and medically~~. When eligibility or ineligibility for ~~Personal Care~~SPPC is established, the local OKDHS office updates the computer-generated ~~form~~notice and the appropriate notice is mailed to the member.
- (b) **Financial certification period.** The financial certification period for ~~Personal Care~~SPPC services is ~~12~~twelve (12) months. ~~Redetermination of eligibility~~Eligibility redetermination is completed according to the categorical relationship.
- (c) **Medical certification period.** A medical certification period of not more than thirty-six (36) months is assigned for ~~an individual~~member who is approved for ~~Personal Care~~-SPPC. The certification period for ~~Personal Care~~SPPC services is based on the Uniform Comprehensive Assessment Tool (UCAT)-evaluation and clinical judgment of the Oklahoma ~~Department of Human Services (DHS)~~ area nurse or designee:HCMN III.

317:35-15-8. Agency State Plan personal carePersonal Care (SPPC) service authorization and monitoring

- (a) Within ~~10 business~~ten (10) business days of referral receipt of ~~the referral~~ for ~~personal care~~SPPC services, the personal care provider agency nurse completes a ~~Service Authorization Model (SAM) visit in the home to assess on~~an assessment of the member's personal care service needs and completes and submits the packeta person-centered plan based on the member's needs to the ~~DHS nurse~~.Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) I or II. The member's ~~SAM packet includes~~plan includes the:

- (1) 02AG044E, Personal Care Progress Notes; Adv/SPPC-Nurse Evaluation;

- (2) ~~02AG030E, Personal Care Planning Schedule/Service Plan;~~ SPPC-Service Planning; and
(3) ~~02AG029E, Personal Care Plan.~~ SPPC Member Service Agreement.

(b) When more than one (1) person in the household ~~was~~ referred to receive ~~personal care~~ SPPC or ADvantage services, all household members' ~~SAM packets~~ plans are discussed and developed with the eligible members so service delivery is coordinated to achieve the most efficient use of resources. The number of SPPC service units of ~~personal care service~~ authorized for each individual is distributed between all eligible family members, ~~to ensure that the absence of one family member~~ This ensures one (1) family member's absence does not adversely affect the family member(s) remaining in the home. When one (1) or more persons in the same household with a ~~personal care~~ SPPC member ~~were~~ is referred to or ~~are receiving~~ receives other formal services, such as ADvantage or Developmental Disability Services, then those services are coordinated as well.

(c) The personal care provider agency receives documentation from ~~DHS as the~~ OKDHS HCMN I or II for authorization to begin services. The agency ~~delivers~~ provides a copy of the ~~care plan Form 02AG029E and the Personal Care Planning Schedule/Service Plan~~ to the member upon initiating services.

(d) Prior to ~~the provider agency~~ placing a ~~personal care assistant~~ Personal Care Assistant (PCA) in the member's home or other service-delivery setting ~~by the provider agency~~, an Oklahoma State Bureau of Investigation (~~OSBI~~) background check, an Oklahoma State Department of Health Registry check, and an ~~DHS~~ OKDHS Community Services Worker Registry check ~~must be~~ is completed per Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide ~~personal care~~ SPPC services and meet criteria ~~OAC 317:35-15-2(c)(1) 1 through 8).~~ Oklahoma Administrative Code (OAC) 317:35-15-2(c) (1) through (8).

(e) The provider agency nurse monitors the member's ~~care plan of care~~ care plan.

(1) The personal care provider agency nurse or staff contacts the member within ~~five business~~ five (5) business days of authorized document receipt of ~~the authorized document~~ in order to ensure services ~~were~~ are implemented according to the authorized care plan of care.

(2) The provider agency nurse makes a ~~SAM home~~ monitoring visit using the Adv/SPPC Nurse Evaluation at least every six (6) months to assess the member's satisfaction with his or her care and to evaluate the ~~SAM packet~~ care plan for adequacy of goals and authorized units. Whenever a home monitoring visit is made, the provider agency nurse documents findings in the ~~Personal Care Progress Notes~~ electronic system. The provider agency ~~forwards a copy of the Progress Notes to the DHS nurses~~ submits monitoring documentation to the OKDHS HCMN I or II for review within ~~five business~~ five (5) business days of the visit. A registered nurse (RN) conducts the monitoring visit when the PCA is performing hands-on personal care. The A licensed practical nurse may only conduct the monitoring visit ~~may be conducted by a Licensed Practical Nurse (LPN) only~~ when the PCA is not performing hands-on personal care. A Registered Nurse (RN) must also co-sign An RN also co-signs the progress notes.

(3) ~~Requests by the~~ The provider agency ~~nurse~~ nurse's requests to change the number of authorized units ~~authorized in the SAM packet~~ SPPC plan are submitted via the electronic system to ~~(DHS) the OKDHS HCMN III and are approved or denied by the (DHS) area nurse or designee,~~ to approve or deny prior to changed number of authorized units ~~unit~~ implementation.

(4) Annually, or more frequently when the member's needs change, the provider agency nurse re-assesses the member's ~~need's~~ needs and develops a new ~~SAM packet~~ plan to meet the member's needs. The provider agency nurse ~~conducts a home visit and completes and submits~~

the annual reassessment documents to the ~~DHS nurse~~ OKDHS HCMN I or II no sooner than ~~60 calendar~~ sixty (60) calendar days before the existing service plan end-date, and no later than ~~14 calendar~~ fourteen (14) calendar days prior to service.

(5) When the member is unstaffed, the provider agency nurse or staff communicates with the member and makes efforts to re-staff. ~~It is recommended the provider agency contacts unstaffed members weekly by phone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff.~~ When consecutively unstaffed for seven (7) calendar days, or fewer depending on the member's needs, the provider agency nurse or staff contacts the unstaffed member weekly by phone to actively monitor the member's health and safety and documents ongoing efforts to provide staff using the electronic system. When the member is unstaffed for ~~30 calendar~~ thirty (30) days, the provider agency notifies the ~~DHS nurse on Form 02AG032E, Provider Communication Form.~~ OKDHS HCMN I or II via the Case Note for SPPC thirty (30) day unstaffed note in the electronic system. The DHS nurse The HCMN I or II contacts the member and when the member chooses, initiates a member transfer of the member to another provider agency that can provide staff.

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 ~~behalf of the~~ 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. Personal Care (SPPC).** Payment for ~~personal care~~ SPPC services is made for care provided in the member's ~~"own home"~~ own home or in other limited living arrangement types ~~of living arrangements,~~ per ~~OAC~~ Oklahoma Administrative Code (OAC) 317:35-15-2(b)(1 through 4).

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

(B) **Reimbursement.** ~~Personal care~~ SPPC services payment on a member's behalf ~~of a member~~ is made according to the service type ~~of service~~ and number of units of personal care services authorized in the Service Authorization Model (SAM) packet. authorized service units.

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

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

SAM nursing visit.

(iii) ~~Service~~SPPC service time for ~~personal care services~~ is documented through the use of 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 the ~~service commencement of services~~. 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 ~~Personal Care~~SPPC provider agency or the assigned PCA and has exhausted attempts to work with the ~~Personal Care provider agency's~~ grievance process without resolution, the member is referred to the ~~DHS~~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 ~~and/or~~ the PCA as appropriate. Provider agency staff counsels the PCA regarding problems with ~~his/her~~his or her performance.

(3) Persons ineligible to serve as PCAs-a PCA. Payment from SoonerCare funds for ~~personal care~~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, ~~to whom he/she~~when he or she is providing ~~personal care~~SPPC services ~~(exceptions may be made for legal guardians with prior approval from the Department of Human Services/Aging Services (DHS/AS)).~~

317:35-15-8.2. State Plan Personal Care Eligible Provider Exception [REVOKED]

~~The Oklahoma Department of Human Services (OKDHS) Aging Services (AS) may authorize a member's legal guardian to be eligible for SoonerCare (Medicaid) reimbursement when he or she is hired by a home care provider agency as a personal care service provider. Authorization for a legal guardian as a provider requires the criteria in (1) through (4) of this Section and monitoring provisions to be met.~~

~~(1) Authorization for a legal guardian to be the member's care provider may occur only when the member is offered a choice of providers and documentation demonstrates:~~

~~(A) Another provider is not available; or~~

~~(B) The member's needs are so extensive that the legal guardian providing the care is prohibited from obtaining employment.~~

~~(2) The service must:~~

~~(A) Fall under the State Plan Personal Care (SPPC) program guidelines;~~

~~(B) Be necessary to avoid institutionalization;~~

~~(C) Be a service and/or support specified in the person-centered service plan;~~

~~(D) Be provided by a person who meets provider qualifications;~~

~~(E) Be paid at a rate that does not exceed what would be paid to a provider of a similar service and does not exceed what is allowed by Medicaid (SoonerCare) for the payment of personal care or personal assistance services; and~~

~~(F) Not be an activity the legal guardian would ordinarily perform or is responsible to perform.~~

~~(3) The legal guardian service provider complies with:~~

- (A) ~~Providing no more than forty (40) hours of services in a seven (7) calendar day period;~~
 - (B) ~~Planned work schedules that must be available in advance for the member's home care agency. Variations to the schedule must be noted and supplied to the home care agency two (2) weeks in advance unless the change is due to an emergency;~~
 - (C) ~~Utilization of the Electronic Visit Verification System (EVV) also known as the Interactive Voice Response Authentication (IVRA) system; and~~
 - (D) ~~Being identified and monitored by the home care agency.~~
- (4) ~~The home care agency is required to submit a request and obtain approval for eligible provider exceptions to OKDHS AS prior to employing a legal guardian as a member's personal care assistant (PCA). Eligible provider exceptions require the home care agency to:~~
- (A) ~~Provide monitoring and complete the Eligible Provider Exception Six Month Review document, when in the member's home completing the six month Nurse Evaluation document in the Medicaid waiver information system; and~~
 - (B) ~~Annually complete the Eligible Provider Exception Request and submit it with the annual Service Authorization Model (SAM) documentation no later than forty five (45) calendar days prior to the previous eligible provider exception service authorization end date.~~

317:35-15-9. ~~Redetermination of financial~~Financial eligibility redetermination for State Plan Personal Care

~~The OKDHS county Social Services Specialist must complete~~Oklahoma Human Services social services specialist completes a redetermination of financial eligibility redetermination before the end of the certification period. A notice is generated only if there is a change ~~which affects~~affecting the member's financial eligibility.

317:35-15-10. ~~Redetermination of medical~~Medical eligibility redetermination for personal careState Plan Personal Care (SPPC) services

(a) **Medical eligibility redetermination.** ~~The Oklahoma Department of Human Services (DHS) area nurse must complete a~~(OKDHS) Health Care Management Nurse (HCMN) III completes a medical redetermination of ~~medical eligibility~~ before the end of the long-term care medical certification period.

(b) **Recertification.** ~~The DHS nurse~~OKDHS HCMN I or II re-assesses the ~~personal care services member,~~SPPC service members eighteen (18) years of age and older, for medical re-certification based on the member's needs and level of caregiver support required, using the Uniform Comprehensive Assessment Tool (UCAT) ~~Part III~~ at least every thirty-six (36) months. ~~Those members, who are~~Members younger than eighteen (18) years of age, are re-evaluated by the ~~DHS nurse~~OKDHS HCMN I or II using the UCAT ~~Part III~~ on a twelve (12) month basis or sooner when needed. During this re-certification assessment, the ~~DHS nurse~~OKDHS HCMN I or II informs the member of the state's other ~~SoonerCare~~ (Medicaid) long-term care options. The ~~DHS nurse~~OKDHS HCMN I or II submits the re-assessment to the ~~DHS area nurse~~OKDHS HCMN III for recertification. Documentation is sent to the ~~DHS~~OKDHS area nurse no later than the ~~tenth~~ tenth (10th) calendar day of the month in ~~which the certification expires.~~

When the ~~DHS area nurse~~OKDHS HCMN III determines medical eligibility for ~~personal care~~SPPC services, a recertification review date is entered on the system.

(c) **Change in amount of units or tasks.** When the ~~personal care~~SPPC provider agency determines a need for a change in the amount of units or tasks ~~within the personal care~~in the

service, a ~~new Service Authorization Model (SAM) packet~~ care plan is completed and submitted to ~~DHS~~ OKDHS within five (5) business days of identifying the assessed need. The ~~OKDHS HCMN III approves or denies the change is approved or denied by the DHS area nurse or designee,~~ OKDHS HCMN III approves or denies the change is approved or denied by the DHS area nurse or designee, prior to implementation.

(d) ~~Voluntary closure of personal care services.~~ **SPPC services voluntary closure.** When a SPPC member decides personal care services are no longer needed to meet his or her needs, a medical decision is not needed. The member ~~and the DHS nurse or DHS county Social Services Specialist completes and signs DHS Form 02AG038E, State Plan Personal Care/ADvantage Program is sent a Voluntary Withdrawal Request; for confirmation and signature, and the request is entered into the electronic system upon receipt. The DHS nurse submits~~ a closure notification is submitted to the provider agency; ~~via the electronic system.~~

(e) **Resuming personal care services.** When a SPPC member approved for ~~personal care~~ SPPC services is without ~~personal care services for less than ninety calendar (90 calendar)~~ ninety (90) calendar days, but the member has current medical and SoonerCare (Medicaid) financial eligibility approval, ~~personal care~~ SPPC services may be resumed using the member's previously approved SAM packet plan. The personal care provider agency nurse contacts the member to determine when changes in health or service needs occurred. When changes are identified, the provider agency nurse ~~makes a home~~ completes an assessment visit and submits a ~~personal care~~ SPPC services skilled nursing need re-assessment of need within ~~ten business (10 business)~~ ten (10) business days of the resumed plan start date, ~~using the State Plan Personal Care Progress Notes, DHS Form 02AG044E. When the member's needs dictate, the personal care provider agency may submit a request for a change in authorized personal care services SPPC service units with a SAM packet to DHS. When no changes occur, the agency nurse documents the contact on State Plan Personal Provider Communication Form 02AG032E and forwards it to the DHS nurse within ten business (10 business)~~ in the electronic system for the OKDHS HCMN I or II ten (10) business days of the resumed plan start date.

(f) **Financial ineligibility.** When the ~~DHS~~ OKDHS social services specialist (SSS) determines a ~~personal care services member does not meet SoonerCare (Medicaid) financial eligibility criteria,~~ the ~~DHS office notifies the DHS area nurse~~ OKDHS HCMN III is notified to initiate the closure process due to financial ineligibility. ~~Individuals determined~~ When OKDHS determines a member to be financially ineligible for ~~personal care~~ SPPC services, ~~are notified by DHS~~ they notify the member of the determination, and his or her right to appeal the decision in writing ~~of the determination and of their right to appeal the decision. The DHS nurse submits~~ a closure notification is submitted to the provider agency.

(g) **Closure due to medical ineligibility.** ~~Individuals determined~~ When OKDHS determines to be medically ineligible for ~~personal care~~ SPPC services ~~are notified by DHS,~~ they notify the member of the determination, and his or her right to appeal the decision, in writing ~~of the determination and of their right to appeal the decision.~~ When medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until ~~care level of care~~ redetermination is established. For members:

- (1) ~~who~~ Who are not hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for a maximum ~~sixty calendar (60 calendar)~~ sixty (60) calendar days from the date of the previous medical eligibility expiration date;
- (2) ~~who~~ Who are hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for ~~thirty calendar (30 calendar)~~ thirty (30) calendar days from the date of discharge from the facility or for ~~sixty calendar (60 calendar)~~ sixty (60) calendar days.

calendar days from the date of previous medical eligibility expiration date, whichever is longer;

(3) ~~whose~~Whose medical eligibility redetermination is not made by applicable extended deadline, the member is determined to be ~~no longer medically eligible;~~ineligible; or

(4) ~~who~~Who no longer meet medical eligibility or cannot be located to complete the redetermination assessment, ~~the area nurse or nurse designee,~~the HCMN I or II notifies the HCMN III. The HCMN III updates the system's medical eligibility end date and notifies the DHS State Plan Care Unit (SPCU) nurse HCMN I or II of effective end date. The DHS SPCU nurse submitsA closure notification is submitted to the provider agency.

(h) **Termination of State Plan personal care services. Personal Care services termination.**

(1) ~~Personal care~~State Plan Personal Care (SPPC) services may be discontinued when:

(A) ~~the~~Professional documentation supports the member poses a threat to self or others as ~~supported by professional documentation;~~

(B) ~~other~~Other household members of the household or persons who routinely visit the household who, as supported by professional or credible documentation or other credible documentation, supports, pose a threat to the member or other household visitors;

(C) ~~the~~The member or the other household members use threatening, intimidating, degrading, or sexually inappropriate language ~~and/or~~or innuendo or behavior towards service providers, either in the home or through other contact or communications; ~~and efforts. Efforts~~ to correct such behavior ~~were~~are unsuccessful as ~~supported by professional or credible documentation or other credible documentation, supports;~~

(D) ~~the~~The member or family member fails to cooperate with ~~Personal Care~~SPPC service delivery or to comply with Oklahoma Health Care Authority (OHCA) or ~~DHS~~OKDHS rules as ~~supported by professional or credible documentation; supports;~~

(E) ~~the~~The member's health or safety is at risk as ~~supported by professional or credible documentation; supports;~~

(F) ~~additional~~Additional services, either "formal" such as, paid by Sooner Care (Medicaid) or some other funding source or "informal" such as, unpaid are provided in the home ~~eliminating. This eliminates~~ the need for SoonerCare ~~personal care~~SPPC services;

(G) ~~the individual's~~The member's living environment poses a physical threat to self or others as ~~supported by professional or credible documentation supports where applicable,~~ and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible; or

(H) ~~the~~The member refuses to select ~~and/or~~or accept ~~the services of a provider agency or personal care assistant (PCA)~~Personal Care Assistant (PCA) service for ninety-consecutive (90 consecutive) ninety (90) consecutive days as supported by professional or credible documentation; supports.

(2) For ~~persons~~members receiving ~~personal care~~SPPC services, the ~~personal care~~ provider agency submits documentation with the recommendation to discontinue services to ~~DHS.~~OKDHS. The ~~DHS nurse~~OKDHS HCMN I or II reviews the documentation and submits it to the ~~DHS area nurse~~OKDHS HCMN III for determination. The ~~DHS nurse~~ notifies the personal care provider agency or PCA and the local ~~DHS county worker~~OKDHS social services specialist is notified of the decision to terminate services; via the electronic system. The member is sent an official closure notice informing him or her of appropriate member rights to appeal the decision to discontinue services.

317:35-15-12. Case changes

Any time there are changes ~~which affect~~ affecting the State Plan Personal Care case, eligibility, computer generated notices are issued.

317:35-15-13.1. Individual personal care assistant (IPCA) service management

(a) An Individual Personal Care Assistant (IPCA) may be utilized to provide ~~personal care~~ SPPC services when it is documented to be in the member's best interest of the member to have an IPCA, or when there are no qualified personal care provider agencies available in the member's local area. Oklahoma Health Care Authority (OHCA) checks the list of providers barred from Medicare/Medicaid participation to ensure the IPCA is not listed.

(b) After ~~personal care~~ SPPC services eligibility is established, and prior to implementation of ~~personal care~~ SPPC services using an IPCA, the ~~DHS nurse~~ OKDHS Health Care Management Nurse I or II reviews the care plan with the member and IPCA and notifies ~~the member and IPCA~~ them to begin ~~personal care~~ SPPC services delivery. The ~~DHS nurse~~ OKDHS HCMN I or II maintains the original care plan and forwards a copy ~~of the care plan~~ to the selected IPCA and member within ~~one business~~ one (1) business day of approval receipt of approval.

(c) The ~~DHS nurse~~ HCMN I or II contacts the member within ~~five business~~ five (5) business days to ensure services are in place and meeting the member's needs. The HCMN I or II also and monitors the care plan for members with an IPCA. For any member receiving ~~personal care~~ SPPC services utilizing an IPCA, the ~~DHS nurse~~ OKDHS HCMN I or II makes a home visit at least every six ~~(6)~~ months beginning within ~~90 calendar~~ ninety (90) calendar days from the date of ~~personal care~~ service initiation. ~~DHS~~ OKDHS HCMN I or II assesses the member's satisfaction with his or her ~~personal care~~ SPPC services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan ~~must be~~ approved by the ~~DHS area nurse or designee,~~ HCMN III prior to implementation ~~of the changed number of units~~.

317:35-15-13.2. Individual personal care assistants (IPCA) provider contractor; billing, training, and problem resolution

While the Oklahoma Health Care Authority (OHCA) is the contractor authorized under federal law, the Oklahoma ~~Department of Human Services (DHS) nurse~~ (OKDHS) Health Care Management Nurse (HCMN) I or II initiates initial contracts with ~~qualified individuals for provision of personal care~~ eligible members to provide SPPC services per Oklahoma Administrative Code (OAC) 317:35-15-2. The OHCA is responsible for IPCA contract renewal for the IPCA is the responsibility of OHCA.

(1) **IPCA payment.** Payment for ~~personal care~~ SPPC services is made for care provided in the member's ~~"own home"~~ own home or in other limited types of living arrangements per OAC 317:35-15-2(b)(1) through (4). Personal care SPPC services may not be approved when the ~~client~~ member lives in the Personal Care Assistant's ~~(PCA's)~~ (PCA) home, except with the approval of ~~DHS~~ OKDHS Community Living, Aging Services, and Protective Services.

(A) **Reimbursement.** Personal care payment for a member is made according to the number of personal care units of service identified in the service plan.

(i) The amount per unit ~~amounts~~ paid to individual contractors is determined according to the established rates. A service plan is developed for each eligible individual member in the home and service units of service are assigned to meet ~~the~~ each member's needs ~~of each member~~. The service plans combine units in the

~~most efficient manner~~efficiently to meet the needs of all eligible personsmembers needs in the household.

(ii) From the total amounts billed by the IPCA bills in (i) of this subparagraph, the OHCA, acting as agent for the member-employer, withholds the appropriate FICA tax percentage of FICA tax and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To ensure the Social Security account is credited, the individual contractor's Social Security account may be properly credited, it is vital that the individual contractor's Social Security number be entered correctly on each claim.

(iii) The contractor payment fee covers all ~~personal care~~SPPC services included on the service and care plans developed by the DHS nurse.the OKDHS HCMN I or II develops. Payment is only made for eligible members' direct services and care of the eligible member(s) only. The area nurse, or designee,OKDHS HCMN III, authorizes the number of ~~units of service~~ units the member receives.

(iv) A member may select more than one (1) IPCA. This may beThe service and care plan indicates when this is necessary as indicated by the service and care plans.

(v) The IPCA may provide SoonerCare ~~personal care~~SPPC services for several households during one (1) week as long as the daily number of paid service units does not exceed eight (8) hours, ~~32~~thirty-two (32) units per day. The total number ofTotal weekly hours per week cannot exceed 40, ~~160~~units.forty (40), one-hundred and sixty (160) units.

(B) **Release of IPCA wage and/or employment information for IPCAs release.** Any inquiry received by the local office requesting wage and/or employment information for an IPCA is forwarded to the OHCA, Claims Resolution.

(2) **IPCA member selection.** Members and/or family members recruit, interview, conduct reference checks, and select the individual applicants for IPCA consideration. Prior to placing a ~~personal care service provider~~an IPCA in the member's home, an OSBIOklahoma State Bureau of Investigation (OSBI) background check, a DHS and an OKDHS Community Services Worker Registry check ~~must be~~are completed per Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. (O.S. 63 §§ 1-1944 through 1-948). The DHS nurse ~~must also check~~OKDHS HCMN I or II also checks the Certified Nurse Aide Registry. The DHS nurse ~~must affirm that~~OKDHS HCMN I or II affirms the applicant's name is not contained on any of the registries. The DHS nurseOKDHS HCMN I or II notifies OHCA when the applicant is on the Registry.any registry.

(A) **Persons eligible to serve as IPCAs.** ~~Payment~~SPPC services payment is made for ~~personal care services to IPCAs who provide personal care services who~~ meet the criteria per OAC 317:35-15-2(c)(1) through (8).

(B) **Persons ineligible to serve as IPCAs.** ~~Payment~~SPPC services payment from SoonerCare funds for ~~personal care services~~ may not be made to an individual who is ~~at the member's~~ legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served, ~~exceptions to legal guardian are made only with prior approval from Aging Services Division.~~

(i) Payment cannot be made to a ~~DHS or~~ an OKDHS or OHCA employee. Payment cannot be made to an immediate family member of a ~~DHS~~an OKDHS employee who works in the same county without ~~DHS Aging Services~~OKDHS Medicaid Services Unit approval. When a family member relationship exists between a ~~DHS nurse~~an

OKDHS HCMN I or II and an IPCA in the same county, the ~~DHS nurse~~OKDHS HCMN I or II cannot manage services for a member whose IPCA is his or her family member of the ~~DHS nurse~~.

(ii) If it is determined that ~~an a DHS~~an OKDHS HCMN I or II or an OHCA employee is interfering in the process of providing servicesservice provision for personal or family benefit, he or shethe employee is subject to disciplinary action.

(3) **IPCA orientation.** When a member selects an IPCA, the ~~DHS nurse~~OKDHS HCMN I or II notifies the individual selected IPCA to report to the county office to complete the Oklahoma State Department of Health~~form~~(OSDH) Form 805, Uniform Employment Application for Nurse Aide Staff, and the ~~DHS~~OKDHS Form 06PE039E, Employment Application Supplement, and for a qualification determination of qualificationsand orientation: determination. For personal careSPPC members, this process is the responsibility of the ~~DHS nurse~~OKDHS HCMN I or II responsibility. The IPCA can begin work when:after:

(A) he or she was interviewed by the member,The member interviews him or her;

(B) he or she was oriented by theThe OKDHS nurse, orients him or her;

(C) he or she executed a contract (OHCA-0026) is executed with the OHCA,;

(D) theThe effective service date wasis established,;

(E) allAll registries wereare checked and the IPCA's name is not listed,;

(F) the Oklahoma State Department of HealthOSDH Nurse Aide Registry wasis checked and no notations wereare found,; and

(G) theOSBI background check wasis completed.

(4) **Training of IPCAs.**IPCA training. It is the responsibility of the ~~DHS nurse~~OKDHS HCMN I or II responsibility to make sure the IPCA has the training needed to carry out the care plan of care prior to each member's service initiation for each member.

(5) **Problem resolution related to the**IPCA performance of the IPCA. When it comes to the attention of the ~~DHS nurse~~thatOKDHS HCMN I or II attention there is a problem related to the IPCA performance of the IPCA, a counseling conference is held between the member, ~~OKDHS nurse,~~HCMN I or II, and worker.IPCAs. The ~~DHS nurse~~OKDHS HCMN I or II counsels the IPCA regarding problems with his or her performance. Counseling is considered when staff believes counseling will result when doing so results in improved performance.

(6) **Termination of the IPCA Provider Agreement.** termination.

(A) AAn IPCA contract termination recommendation for the termination of an IPCA's contract is submitted to OHCA and IPCA services are suspended immediately when: the IPCA:

(i) an IPCA's performance is such that his or her continued participation in the program could posePerformance poses a threat to the member's health and safety of the member or to others; or

(ii) the IPCA failedFailed to comply with the expectations outlined in the PCA Provider Agreement expectations and counseling is not appropriate or was not effective; or

(iii) an IPCA's nameName appears on the ~~DHS~~OKDHS Community Services Worker Registry; or any of the registriesregistry listed in Section 1-1947 of TitleO.S. 63 of the Oklahoma Statutes, § 1-1947, even though his or her name may not have appeared on the Registrywhen his or her name is not on the registry at the time of application or hiring.

(B) ~~The DHS nurse~~OKDHS HCMN makes the IPCA termination recommendation for ~~the termination of the IPCA to DHS~~to OKDHS Community Living, Aging and Protective Services Medicaid Services Unit (MSU), who notifiesMSU then notifies the OHCA Legal Division of the recommendation. When the problem is related to abuse, neglect, or exploitation ~~allegations of abuse, neglect, or exploitation,~~DHS~~OKDHS~~ Adult Protective Services, State Attorney General's Medicaid Unit, OHCA, and ~~the Oklahoma State Department of Health~~OSDH are notified ~~by the DHS nurse~~.

(C) When the problem is related to abuse, neglect, or exploitation ~~allegations, of abuse, neglect, or exploitation~~ the ~~DHS nurse~~OKDHS HCMN follows the process, ~~as outlined in~~per OAC 340:100-3-39.

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

Billing procedures for ~~personal care~~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 ~~a study of~~studying the manual are referred to the Oklahoma Health Care Authority (OHCA). ~~Contractors for Personal Care~~SPPC contractors bill on CMS-1500 claim form. OHCA provides instructions to ~~an~~a ~~contracted~~ Individual ~~personal care assistant~~Personal Care Assistant (IPCA) ~~contracted provider~~ for claim completion ~~of the claim~~ at the ~~time of the contractor~~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 ~~were~~are properly completed. All personal care contractors must have a unique provider number. New contracted providers are mailed the provider number after ~~they are~~being placed on the claims processing contractor's provider file. All services provided in the ~~service recipients~~member's home, ~~member's home~~ including Personal Care and Nursing ~~must be,~~ and all work completed in the provider's office, are documented through the Electronic Visit Verification (EVV) system. ~~Additionally, work completed in the provider's office is documented in the 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.

317:35-15-15. ~~Referral for social services~~Social services referral

In many situations, members ~~who are~~ receiving medical services through SoonerCare (Medicaid) need social services. The OKDHS ~~nurse~~HCMN I or II may make referrals for social services to the OKDHS ~~workers~~social services specialist (SSS) in the local office. In addition to these referrals, a member, or another individual acting on the member's behalf, may initiate a social services request ~~for social services may be initiated by a member or by another individual acting upon behalf of a member.~~

- (1) ~~The OKDHS Social Services Specialist~~SSS is responsible for ~~providing~~provides the indicated services, or ~~for referral~~makes referrals to the appropriate ~~resource outside the Department~~outside resources if the services are not available within ~~the Department~~OKDHS.
- (2) ~~Among the OKDHS SSS provided services provided by the OKDHS Social Services Specialist are:~~

(A) ~~Services that will enable individuals~~Enable members to attain ~~and/or~~or maintain as

good physical and mental health ~~as possible~~;

(B) ~~Services to assist patients~~ Assist members who ~~are receiving~~ receive care outside their own homes in planning for and returning to their own homes or to other alternate care;

(C) ~~Services to encourage~~ Encourage the development and maintenance of family and community ~~interest~~ interests and ties;

(D) ~~Services to promote~~ Promote member's maximum independence in the ~~management of managing~~ their own affairs;

(E) ~~Protective~~ Include protective services, including evaluation of that evaluate the need for and arranging for arrange guardianship; and

(F) ~~Appropriate~~ Offer family planning services, ~~which include assisting the~~ including family assistance in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-5. ADvantage program medical eligibility determination

The Oklahoma ~~Department~~ of Human Services (~~DHS~~) OKDHS area nurse or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) ~~Parts I and III~~, and any other available medical information.

(1) When ADvantage care services are requested or the UCAT application is received ~~in the county office~~, the:

(A) ~~DHS~~ OKDHS nurse is ~~responsible for completing~~ completes the UCAT ~~III~~; and

(B) ~~social service~~ Social services specialist (SSS) is ~~responsible for contacting~~ contacts the applicant within three (3) business days to initiate the financial eligibility application process.

(2) Categorical relationship ~~must be~~ established for ADvantage services eligibility determination ~~of eligibility for ADvantage services~~. When a member's categorical relationship to a disability ~~was~~ is not established, the local ~~social service specialist~~ SSS submits the same information, per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) of the Oklahoma Health Care Authority to request a medical categorical relationship eligibility determination ~~of eligibility for categorical relationship~~. LOCEU ~~renders a decision~~ decides on the categorical relationship to ~~the person with~~ the disability using the Social Security Administration (SSA) definition. ~~A~~ An SSS follow-up with SSA is required ~~by the DHS social service specialist with SSA~~ to ensure the disability decision agrees with the LOCEU decision.

(3) Community agencies and waiver service applicants may complete the UCAT I application and forward ~~the form to the county office.~~ OKDHS. When the UCAT I indicates the applicant does not qualify for Medicaid long term care services, the applicant is referred to appropriate ~~community resources~~. Members may call the care line at 1-800-435-4711.

(4) ~~The DHS~~ When an applicant is Medicaid eligible at the request time, an OKDHS nurse completes the UCAT ~~III~~ assessment ~~visit~~ with the member applicant within ~~10 business~~ ten (10) business days of referral receipt ~~of the referral~~ for ADvantage services ~~for an applicant who is Medicaid eligible at the time of the request~~. The ~~DHS~~ OKDHS nurse completes the UCAT ~~III~~ assessment ~~visit~~ within ~~20 business~~ twenty (20) business days of the date the Medicaid application is completed for new applicants.

~~(5)~~ For initial level of care (LOC), the OKDHS nurse assesses the applicant through an electronic format such as phone or video conference, using the UCAT unless there are limiting factors which necessitate a face-to-face assessment.

~~(A)~~ The OKDHS nurse determines LOC based upon the assessment outcome unless the applicant is medically ineligible. In this case, a face-to-face visit is scheduled to either validate the initial electronic format assessment or to provide additional documentation to support the applicant meeting medical LOC.

~~(B)~~ Applicants are not denied access to the waiver solely based on an assessment completed through an electronic format.

~~(5)(6)~~ During the UCAT ~~III~~-assessment-visit, the ~~DHS~~OKDHS nurse informs the applicant of medical eligibility criteria and provides information about the different long-term care service options. ~~When there are multiple household members applying for the ADvantage program, the UCAT assessment is done for them during the same visit.~~ The ~~DHS~~OKDHS nurse documents whether the ~~member~~applicant chooses nursing facility program services or ADvantage program services and makes a level of care an LOC and service program recommendation.

~~(6)(7)~~ The ~~DHS~~OKDHS nurse informs the ~~member~~applicant and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the applicant's primary and secondary informed ~~choices~~, provider choice, ensuring adherence to conflict free case management requirements.

~~(A)~~ ~~Providers of ADvantage services for the member, providers, or for those who have an interest in, or are employed by an ADvantage provider, for the member must not do not~~ provide case management or develop the person-centered service plan, ~~except~~ The only exception is when the ADvantage Administration (AA) demonstrates the only there are no more than two (2) willing and qualified entity/entities to provide case management and/or and develop person-centered service plans in a geographic area, and those agencies also provides provide other ADvantage services.

~~(B)~~ When the ~~member and/or~~applicant or family declines to make a provider choice, the ~~DHS~~OKDHS nurse documents the decision on ~~Form 02CB001, Member Consents and Rights~~ the consents and rights document.

~~(C)~~ The ~~AA~~OKDHS uses a rotating system to select ~~an agency~~agencies for the ~~member~~applicant from a list of all local, certified case management and in-home care ~~agencies, providers,~~ ensuring adherence to conflict free case management requirements.

~~(7)(8)~~ The ~~DHS~~OKDHS nurse documents ~~the chosen agency names of the chosen agencies, or the choice to decline to select agencies, and the applicant's agreement of the member, by dated signature, to receive waiver services provided by the agencies.~~

~~(8)(9)~~ When the ~~member's~~applicant's needs require an immediate interdisciplinary team (IDT) meeting with the case manager and home health care provider agency nurse participation to develop a person-centered service plan, the ~~DHS~~OKDHS nurse documents the priority processing need for priority processing.

~~(9)(10)~~ The ~~DHS~~OKDHS nurse scores the UCAT ~~III~~. The ~~DHS~~ nurse forwards the completed UCAT III and documentation of financial eligibility, documentation of the member's case management and in-home care agency choices to the area nurse or nurse designee for medical eligibility determination.

~~(10)(11)~~ When based upon the information obtained during the OKDHS nurse determines the UCAT ~~the assessment,~~ the ~~DHS~~ nurse determines indicates the member may be health and

safety are at risk for health and safety, DHSOKDHS Adult Protective Services staff is notified immediately and the referral is documented on the UCAT.

~~(11)~~(12) Within ~~10 business~~ (10) business days of receipt of a complete ADvantage application, the area nurse or nurse designee determines medical eligibility using nursing facility ~~level of care~~LOC criteria and service eligibility criteria, per OAC 317:35-17-2 and 317:35-17-3, and enters the medical decision on the system.

~~(12)~~(13) Upon ~~SSS financial eligibility~~ notification of ~~financial eligibility from the social service specialist, medical eligibility,~~ and medical eligibility approval for ADvantage entry from the area nurse or nurse designee, ~~the AA~~ communicates with the case management provider to begin care and service plan development. ~~The AA communicates to the case management provider, the member's name, address, case number, Social Security number, AA provides the member's demographic and assessment information, and the number of units of case management and the number of units of home care agency nurse evaluation units authorized for service plan development.~~ When the member requires an immediate home visit to develop a person-centered ~~within 24 hours, the plan,~~ AA contacts the case management provider directly to confirm availability and request IDT priority ~~electronically sends the new case packet information to the case management provider.~~

~~(13)~~(14) When ~~the~~ a member is being discharged from a nursing facility or hospital and transferred home, services ~~must be~~ are in place to ensure the member's health and safety ~~of the member upon discharge to the home from the nursing facility or hospital,~~ a. The member's chosen case manager from an ADvantage case management provider selected by the member and referred by the AA follows the ADvantage institutioninstitutional transition; case management procedures for care, and service plan development and implementation.

~~(14)~~(15) A new medical ~~level of care~~LOC determination is required when a member requests any ~~changes~~change in service ~~program, setting,~~ from:

- (A) State Plan Personal Care (SPPC) services to ADvantage services;
- (B) ADvantage to ~~State Plan Personal Care~~SPPC services;
- (C) ~~nursing~~Nursing facility to ADvantage services; or
- (D) ADvantage to nursing facility services.

~~(15)~~(16) A new medical ~~level of care~~LOC determination is not required when a member requests ADvantage services re-activation of ADvantage services after a short term stay of 90 calendar ~~staying ninety (90) calendar~~ days or less in a nursing facility when the member had previous ADvantage services and the ADvantage certification period has not expired: by the date the member is discharged.

~~(16)~~(17) When a UCAT assessment ~~was~~ is completed more than ~~90 calendar~~ ninety (90) calendar days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

317:35-17-16. Member annual level of care re-evaluation and annual service plan reauthorization

(a) The ADvantage case manager reassesses the member's needs annually using the Uniform Comprehensive Assessment Tool (UCAT) ~~Parts I and III,~~ then evaluates the member's progress ~~of the member~~ toward person-centered service plan goals and objectives. The ADvantage case manager develops the annual person-centered service plan with the member and interdisciplinary team and submits the person-centered service plan to the ADvantage Administration (AA) for authorization. The ADvantage case manager initiates the UCAT reassessment and ~~development~~

~~of~~ develops the annual person-centered service plan at least forty (40) calendar days, but not more than sixty (60) calendar days, prior to the existing plan's end date ~~of the existing person-centered service plan~~. The ADvantage case manager provides AA the ~~reassessment~~ person-centered service plan packet ~~reassessment documents~~ no less than thirty (30) calendar days prior to the existing plan's end date ~~of the existing plan~~. The ~~reassessment person-centered service plan packet~~ documents include the person-centered service plan, UCAT ~~Parts I and III~~, Nursing Assessment and Monitoring Tool and supporting documentation.

(b) For medical eligibility reassessment, ~~The Oklahoma Department of Human Services (DHS)(OKDHS) recertification~~ nurse reviews the UCAT ~~Parts I and III~~ the ADvantage case manager submitted ~~by the ADvantage case manager for a level of care redetermination~~. When policy defined criteria for nursing facility level of care LOC cannot be determined or justified from available documentation or through direct contact with the ADvantage case manager, the member is referred to the local OKDHS nurse. ~~UCAT Parts I and III are completed in the member's home by the DHS nurse. The DHS nurse submits the UCAT evaluation to the area nurse or nurse designee, to make the medical eligibility level of care determination.~~ The OKDHS nurse then reassesses the applicant using the UCAT through an electronic format such as a phone and video conference, unless there are limiting factors which necessitate a face-to-face assessment.

(1) The OKDHS nurse determines LOC based on the assessment's outcome unless the applicant is determined to be medically ineligible. In this case, a face-to-face visit is scheduled to either validate the electronic format assessment or provide additional documentation to support the applicant meeting medical LOC.

(2) Applicants are not medically denied access to the waiver solely based on an assessment completed through an electronic format.

(c) When medical eligibility redetermination is not made prior to the current medical eligibility expiration, the existing medical eligibility certification is automatically extended.

(1) For members who are not receiving inpatient; acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for a maximum of sixty (60) calendar days from the date of the previous medical eligibility expiration date.

(2) For members who are receiving inpatient; acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for thirty (30) calendar days from the facility discharge date, of discharge from the facility or the for sixty (60) calendar days from the previous medical eligibility's date ~~of the previous medical eligibility date~~, whichever is longer.

(3) When the medical eligibility redetermination is not made by the applicable extended deadline, the member ~~is determined to no longer meet~~ meets medical eligibility. The area nurse or nurse designee updates the system's medical eligibility end date ~~and simultaneously notifies AA electronically.~~

(d) When ~~DHS~~ OKDHS determines a member no longer meets medical eligibility; to receive waiver services, the:

(1) ~~area~~ Area nurse or nurse designee updates the medical eligibility end date ~~and notifies the AA electronically;~~

(2) AA communicates to the member's ADvantage case manager that the member ~~was determined to no longer need~~ meets medical eligibility for ADvantage as of the eligibility determination effective date ~~of the eligibility determination~~; and

(3) ADvantage case manager communicates with the member and when requested, assists with access to other services.

317:35-17-27 Incident reporting

(a) Reporting requirement. Certified ADvantage provider staff should report critical and non-critical incidents involving the health and welfare of ADvantage Waiver members to the Oklahoma Human Services Medicaid Services Unit (MSU).

(b) Critical incidents. Critical incidents are events with potential to cause significant risk or serious harm to an ADvantage member's safety or well-being. Critical Incidents Reports (CIR) are completed for:

- (1) Suspected maltreatment including abuse, neglect, or exploitation, per Section 10-103 of Title 43A of the Oklahoma Statutes (43A O.S. § 10-103);
- (2) Attempted suicide or suicidal ideation exhibition;
- (3) Unexpected or questionable death;
- (4) Falls or injuries requiring medical attention;
- (5) Residence loss due to disaster;
- (6) An interruption of needed medical supports;
- (7) Lost or missing members;
- (8) A medication error requiring medical attention;
- (9) Use of physical restraints; or
- (10) Allegations related to Personal Care Assistant (PCA) or Personal Service Assistant (PSA).

(c) Non-critical incidents. Non-critical incidents are events with potential to cause risk to an ADvantage member's safety and well-being, but do not rise to the critical incident level. Non-critical incidents include:

- (1) Falls or injuries that do not require medical attention;
- (2) Theft allegations;
- (3) Threatening or inappropriate behavior;
- (4) Substance abuse or use;
- (5) Serious allegations related to a provider agency; and
- (6) Law enforcement involvement due to challenging behaviors.

(d) Incident notification requirements. The reporting provider documents and submits to MSU incidents included in (b) and (c) of this Section in the electronic system on the CIR document, within one business day of becoming aware of the incident. The reporting provider notifies other persons or entities as required by law or regulation, including:

- (1) When a service recipient dies, per OAC 340:100-3-35; and
- (2) Investigative authorities immediately in cases of suspected maltreatment, as applicable, including:
 - (A) Local law enforcement;
 - (B) The Office of Client Advocacy when the alleged perpetrator is a community service worker, per OAC 340:2-3-33; and
 - (C) Adult Protective Services when the alleged perpetrator is not a community service worker per 43A O.S. § 10-104.

(e) Internal Investigation. The provider completes an internal investigation of all critical incidents, unless directed otherwise by an authorized government entity.

- (1) All provider investigative reports are submitted to the MSU within ten (10) working days

after the initial CIR is completed.

(2) The provider coordinates internal critical incident investigation and response efforts with governmental investigative authorities as required by law.

(3) Provider supervisory staff run a monthly report from the electronic system to review all critical incidents submitted to the MSU. Doing so ensures proper handling and dispensation occurs, as required by the Centers for Medicare and Medicaid Services.

(f) **Escalated issues.** The Escalated Issues (EI) team reviews all CIR and determines whether the appropriate response occurred. EI coordinates their investigation and response efforts with governmental investigative authorities as required by law. For non-critical incident reports, EI reviews and works with the member, the member's informal support, provider, and others to verify appropriate actions are taken to identify barriers to service, prevent future incidents, and assure continued member health and welfare. Investigation results are communicated to the member, legal guardian, or next of kin as appropriate.

(g) **Members and their representatives.** Upon entry into the program and at least annually, each member is provided with resources and contact information to self-report complaints, abuse, neglect, exploitation, or other issues.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 109. DIABETES SELF-MANAGEMENT TRAINING EDUCATION AND SUPPORT

317:30-5-1080. Definitions

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

~~"AADE" means American Association of Diabetes Educators.~~

"ADA" means American Diabetes Association.

"ADCES" means the Association of Diabetes Care and Education Specialists.

"BC-ADM" means Board-certified advanced diabetes management.

"CDECDCES" means certified diabetes educator/care and education specialist.

"DSMTDSMES" means diabetes self-management training/education and support.

"OAC" means Oklahoma Administrative Code.

"OHCA" means Oklahoma Health Care Authority.

"**Qualified non-physician provider**" means a physician assistant or advanced practice registered nurse.

317:30-5-1081. Eligible providers and requirements

~~(a) Eligible DSMT providers include any of the following professionals:~~

~~(1) A registered dietician (RD) who is licensed and in good standing in the state in which s/he practices, and who is:~~

~~(A) Certified as a CDE; and~~

~~(B) Fully contracted with SoonerCare as a CDE provider.~~

~~(2) A registered nurse (RN) who is licensed and in good standing in the state in which s/he practices, and who is:~~

~~(A) Certified as a CDE; and~~

~~(B) Fully contracted with SoonerCare as a CDE provider.~~

~~(3) A pharmacist who is licensed and in good standing in the state in which s/he practices, and who is:~~

~~(A) Certified as a CDE; and~~

~~(B) Fully contracted with SoonerCare as a CDE provider.~~

~~(b) In order to receive Medicaid reimbursement for DSMT services, professional service groups, outpatient hospitals, Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) must have a DSMT program that meets the quality standards of one (1) of the following accreditation organizations:~~

~~(1) The ADA; or~~

~~(2) The AADE.~~

~~(c) All DSMT programs must adhere to the national standards for diabetes self-management education.~~

~~(1) Each member of the instructional team must:~~

~~(A) Be a CDE; or~~

~~(B) Have documentation of at least fifteen (15) hours of recent diabetes education or~~

diabetes management experience.

~~(2) At a minimum, every instructional team must consist of at least one (1) of the CDE professionals listed in subsection a, above.~~

~~(d) All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.~~

(a) In order to receive Medicaid reimbursement for DSMES services, providers or provider groups must:

(1) Be working under an accredited DSMES program that meets the quality standards of one (1) of the following accreditation organizations:

(A) The ADA; or

(B) The ADCES.

(2) Be fully contracted with SoonerCare as a "diabetes educator". Eligible DSMES providers include:

(A) A registered dietician (RD) who is:

(i) Licensed and in good standing in the state in which s/he practices.

(ii) Has training and experience pertinent to diabetes self-management education and support verified by the OHCA Pharmacy Services unit.

(B) A registered nurse (RN) who is:

(i) Licensed and in good standing in the state in which s/he practices.

(ii) Has training and experience pertinent to diabetes self-management education and support verified by the OHCA Pharmacy Services unit.

(C) A pharmacist who is:

(i) Licensed and in good standing in the state in which s/he practices.

(ii) Has training and experience pertinent to diabetes self-management education and support verified by the OHCA Pharmacy Services unit.

(D) A health care provider, as defined in Section 3090.2 of Title 63 of the Oklahoma Statutes, who holds a certification as a:

(i) CDCES; or

(ii) BC-ADM.

(b) All DSMES programs must adhere to the national standards for diabetes self-management education.

(1) Each DSMES program must include at least one (1) of the eligible providers listed above in OAC 317:30-5-1081 (a) (2) (A) – (D).

(2) All members of the instructional team must complete the nationally recommended annual continuing education hours for diabetes management.

317:30-5-1082. Scope of services

(a) **General provisions.** The OHCA covers medically necessary ~~DSMT~~DSMES services when all the following criteria are met:

(1) The member has been diagnosed with diabetes by a physician or qualified non-physician provider working within the scope of his/her licensure;

(2) The services have been ordered by a physician or qualified non-physician provider who is actively managing the member's diabetes;

(3) The services are provided by a qualified ~~DSMT~~DSMES provider [Refer to OAC 317:30-5-1081~~(b)~~(a)(2)]; and

(4) The program meets the current ADA or ~~AD~~ADCES training standards.

(b) **Training.** ~~DSMT~~DSMES services shall provide one (1) initial assessment per lifetime. Initial

~~DSMTFDSMES~~ shall be comprised of up to ten (10) hours [can be performed in any combination of thirty (30) minute increments] of diabetes training within a consecutive twelve (12) month period beginning with the initial training date, including:

- (1) One (1) hour of individual instruction, consisting of face-to-face encounters between the ~~CDE~~ diabetes educator and the member; and
- (2) Nine (9) hours of group instruction.

(c) **Follow-up ~~DSMTFDSMES~~.** After the first twelve (12) month period has concluded, members shall only be eligible for two (2) hours of individual or group ~~DSMTFDSMES~~ instruction per calendar year.

317:30-5-1083. Coverage by category

The purpose of ~~DSMTFDSMES~~ services must be to provide the member with the knowledge, skill, and ability necessary for diabetes self-care.

(1) **Adults.** Payment is made for medically necessary ~~DSMTFDSMES~~ provided by a ~~registered nurse (RN), registered dietitian (RD), or pharmacist certified as a diabetes educator, as eligible providers~~ described in OAC 317:30-5-1081. Refer to OAC 317:30-5-1082 for units of ~~DSMTFDSMES~~ training allowed.

(2) **Children/adolescents.** Payment is made for medically necessary ~~DSMTFDSMES~~ for members under twenty-one (21) years of age provided by a ~~RN, RD, or pharmacist certified as a diabetes educator, as eligible providers~~ described in OAC 317:30-5-1081. ~~DSMTFDSMES~~ coverage for children is the same as for adults. Additional ~~DSMTFDSMES~~ services may be covered under EPSDT provisions if determined to be medically necessary.

317:30-5-1084. Reimbursement methodology

SoonerCare shall provide reimbursement for ~~DSMTFDSMES~~ services as follow:

(1) Payment shall be made to fully-contracted providers. If the rendering provider operates through an enrolled SoonerCare provider, or is contracted to provide services by an enrolled SoonerCare provider, payment may be made to that enrolled SoonerCare provider.

(2) Reimbursement for ~~DSMTFDSMES~~ services is only made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

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

317:30-5-1090. Provision of other health services outside of the I/T/U encounter

(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service (FFS) contract. The services will be reimbursed at the FFS rate, and will be subject to any limitations, restrictions, or prior authorization requirements. Examples of these services include, but are not limited to:

- (1) Durable medical equipment [refer to Oklahoma Administrative Code (OAC) 317:30-5-210];
- (2) Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);
- (3) Transportation by ambulance (refer to OAC 317:30-5-335);

- (4) Home health (refer to OAC 317:30-5-546);
- (5) Inpatient practitioner services (refer to OAC 317:30-5-1100);
- (6) Non-emergency transportation (~~refer to OAC 317:35-3-2~~);(refer to OAC 317:30-5-326 through 317:30-5-327.9);
- (7) Behavioral health case management (refer to OAC 317:30-5-241.6);
- (8) Psychosocial rehabilitative services (refer to OAC 317:30-5-241.3);
- (9) Psychiatric residential treatment facility services (refer to OAC 317:30-5-95 through 317:30-5-97);
- (10) Applied behavior analysis (ABA) (refer to OAC ~~317:30-3-65.12~~317:30-5-310 through 317:30-5-316); and
- (11) Diabetes self-management ~~training (DSMT)~~education and support (DSMES) (refer to OAC 317:30-5-1080 through 317:30-5-1084).

(b) If the I/T/U facility chooses to provide other Oklahoma Medicaid State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with the Oklahoma Health Care Authority (OHCA) and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.

(c) Providers may bill for antepartum and postpartum visits, and a cesarean or vaginal delivery as individual encounters, or a provider can bill the packaged/bundled rate for total obstetrical care (OB) (which includes antepartum/postpartum visits and delivery). Providers may not bill for both antepartum/postpartum visits and a packaged/bundled rate for total OB care for the same episode of care. Refer to OAC 317:30-5-22 for more detailed obstetrical care policy.

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

SUBCHAPTER 1. GENERAL PROVISIONS

317:30-1-4. Definitions

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

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

"Alien" means an individual who does not have United States citizenship and is not a United States national. It is synonymous with the word "noncitizen".

"CMS" means the Centers for Medicaid and Medicaid Services.

"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.

"Diagnosis Related Group" means a patient classification system that relates types of patients treated to the resources they consume.

"Expansion Adult" means an individual defined by 42 Code of Federal Regulations § 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not categorically related to the aged, blind, and disabled.

"Habilitation" means health care services that are aimed at helping people gain certain new skills, abilities, knowledge and functioning for daily living.

"Noncitizen" means an individual who does not have United States citizenship and is not a United States national. It is synonymous with the word "alien".

"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).

"Rehabilitation" means health care services that help a person to re-gain skills, abilities or knowledge that may have been lost or compromised as a result of acquiring a disability, or due to a change in one's disability or circumstances.

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

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

(a) Medical rules of the Oklahoma Health Care Authority (OHCA) are set by the ~~Oklahoma Health Care Authority~~ OHCA Board. The rules are based upon the recommendations of the Chief Executive Officer of the Authority, ~~the Deputy Administrator for Health Policy~~ the Deputy State Medicaid Director, the ~~Medicaid Operations~~ State Medicaid Director, OHCA Tribal partners and the ~~Advisory Committee on Medical Care for Public Assistance Recipients~~ OHCA Medical Advisory Committee. The ~~Medicaid Operations~~ State Medicaid Director is responsible for implementing medical policies and programs and directing the Fiscal Agent with regard to ~~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 ~~patient~~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.

(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. ~~Well-patient~~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 ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service guidelines.

(f) Services, provided within the scope of the Oklahoma Medicaid ~~Program~~program, shall meet medical necessity criteria. Requests by qualified providers for services in and of itself shall not constitute medical necessity. The ~~Oklahoma Health Care Authority~~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 – 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 ~~client's~~member's need for the service;

(3) Treatment of the ~~client's~~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 ~~client's~~member's age and health status and developed for the ~~client~~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~~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~~Part apply to all providers of service who participate in the program.

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and ~~Community-Based Services Waivers (HCBS)~~community-based services (HCBS) waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Introduction to HCBS waivers for persons with intellectual disabilities.** The Medicaid HCBS waiver programs are authorized per Section 1915(c) of the Social Security Act.

(1) ~~The~~ Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDS) operates HCBS waiver programs for persons with intellectual disabilities and certain persons with related conditions. The Oklahoma Health Care Authority (OHCA), ~~is~~ the State's Medicaid agency, retains and exercises administrative authority over all HCBS waiver programs.

(2) Each waiver allows for the provision of specific SoonerCare-compensable services that assist members to reside in the community and avoid institutionalization.

(3) HCBS waiver services:

(A) ~~complement~~Complement and supplement services available to members through the Medicaid State Plan or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) ~~are~~Are only provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution;

(C) ~~are~~Are not intended to replace other services and supports available to members; and

(D) ~~are~~Are authorized based solely on current need.

(4) HCBS waiver services must be:

(A) ~~appropriate~~Appropriate to the member's needs; and

(B) ~~included~~Included in the member's ~~Individual Plan~~individual plan (IP).

(i) The IP:

(I) ~~is~~Is developed annually by the member's ~~Personal Support Team~~personal support team, per Oklahoma Administrative Code (OAC) 340:100-5-52; and

(II) ~~contains~~Contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

(ii) Services are authorized, per OAC 340:100-3-33 and 340:100-3-33.1.

(5) DDS furnishes case management, targeted case management, and services to members as ~~a~~ Medicaid State Plan services, per Section 1915(g)(1) of the Social Security Act and per OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with an intellectual disability or related conditions.

(1) All providers, except pharmacy, ~~specialized medical supplies~~ and durable medical equipment (DME) providers must be reviewed by ~~DHS~~OKDHS DDS. The review process verifies that:

(A) ~~the~~The provider meets the licensure, certification or other standards specified in the

approved HCBS waiver documents; and

(B) ~~organizations~~Organizations that do not require licensure wanting to provide HCBS services meet program standards, are financially stable and use sound business management practices.

(2) Providers who do not meet program standards in the review process are not approved for a provider agreement.

(3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

(c) **Coverage.** All services must be included in the member's IP and arranged by the member's case manager.

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general ~~SoonerCare coverage~~SoonerCare coverage guidelines for the categorically needy:

(1) ~~Inpatient hospital~~Inpatient hospital services ~~other than those provided in an institution for mental diseases.~~

(A) Adult coverage for ~~inpatient hospital~~inpatient hospital stays as described at OACOklahoma Administrative Code (OAC) 317:30-5-41.

(B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or ~~free-standing~~freestanding dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected ~~outpatient surgical~~outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).

(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified ~~hospital-based~~hospital-based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity clinic services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the ~~agency's~~Agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) ~~Nursing~~Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also

require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA ~~Child Health~~ child-health services are outlined in OAC 317:30-3-65.2 through ~~317:30-3-65.4~~ 317:30-3-65.12.

- (A) ~~Child health screening examinations~~ EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.
 - (B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
 - (C) Immunizations.
 - (D) Outpatient care.
 - (E) Dental services as outlined in OAC 317:30-3-65.8.
 - (F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
 - (G) Hearing services as outlined in OAC 317:30-3-65.9.
 - (H) Prescribed drugs.
 - (I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.
 - (J) Inpatient psychiatric services as outlined in OAC ~~317:30-5-95~~ 317:30-5-94 through 317:30-5-97.
 - (K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
 - (L) Inpatient hospital services.
 - (M) Medical supplies, equipment, appliances ~~and prosthetic devices beyond the normal scope of SoonerCare~~, orthotics and prosthetics.
 - (N) EPSDT services furnished in a qualified child health center.
- (14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.
- (15) Physicians' services whether furnished in the office, the member's home, a hospital, a ~~nursing long-term care facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities~~ intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).
- (16) Medical care and any other type of remedial care recognized under state law, furnished

by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

- (A) Podiatrists' services;
 - (B) Optometrists' services;
 - (C) Psychologists' services;
 - (D) Certified ~~Registered Nurse Anesthetists~~registered nurse anesthetists;
 - (E) Certified ~~Nurse Midwives~~nurse midwives;
 - (F) Advanced ~~Practice Nurses~~practice registered nurses; and
 - (G) Anesthesiologist ~~Assistants~~assistants.
- (17) ~~Free-standing~~Freestanding ambulatory surgery centers.
- (18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:
- (A) ~~unlimited~~Unlimited medically necessary monthly prescriptions for:
 - (i) ~~members~~Members under the age of twenty-one (21) years; and
 - (ii) ~~residents~~Residents of ~~nursing~~long-term care facilities or ICF/IID.
 - (B) ~~seven~~Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) ~~Home and Community Based Services Waivers (HCBS)~~home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.
- (19) Rental and/or purchase of ~~durable medical equipment~~medical supplies, equipment, and appliances.
- (20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.
- (21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).
- (22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.
- (23) Orthotics and prosthetics are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.
- ~~(23)~~(24) Standard medical supplies.
- ~~(24)~~(25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
- ~~(25)~~(26) Blood and blood fractions for members when administered on an outpatient basis.
- ~~(26)~~(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
- ~~(27)~~Nursing(28) Long-term care facility services, limited to members preauthorized and

approved by OHCA for such care.

~~(28)~~(29) Inpatient psychiatric facility admissions for members ~~under twenty-one (21)~~ are limited to an approved length of stay ~~effective July 1, 1992~~, with provision for requests for extensions.

~~(29)~~(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

~~(30)~~(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.

~~(31) Nursing~~(32) Long-term care facility services for members under twenty-one (21) years of age.

~~(32)~~(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a ~~Registered Nurse~~registered nurse (RN).

~~(33) Part A deductible and Part B Medicare Coinsurance and/or deductible~~(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.

~~(34)~~(35) HCBS for the intellectually disabled.

~~(35)~~(36) Home health services ~~limited to~~can be provided without a PA for the first thirty-six (36) visits per year and standard supplies for one (1) month in a twelve (12) month period. A PA will be required beyond the 36th visit. The visits are limited to any combination of ~~Registered Nurse~~RN and nurse aide visits, ~~not to exceed thirty-six (36) per year.~~

~~(36)~~(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

~~(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.~~

~~(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.~~

~~(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.~~

~~(D) Finally, procedures considered experimental or investigational are not covered.~~

(A) All transplantation services, except kidney and cornea, must be prior authorized;

(B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(C) All organ transplants must be performed at a Medicare approved transplantation center;

(D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

(E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

~~(37)~~(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a ~~nursing~~long-term care facility (Alternative Disposition Plan - ADP).

~~(38)~~(39) Case management services for the chronically and/or ~~severely~~seriously mentally ill.

- ~~(39)~~(40) Emergency medical services, including emergency labor and delivery for illegal/undocumented or ineligible aliens.
- ~~(40)~~(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
- ~~(41)~~(42) Early intervention services for children ages zero (0) to three (3).
- ~~(42)~~(43) Residential behavior management in therapeutic foster care setting.
- ~~(43) Birthing center services.~~
- (44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
- (45) HCBS for aged or physically disabled members.
- (46) Outpatient ambulatory services for members infected with tuberculosis.
- (47) Smoking and tobacco use cessation counseling for children and adults.
- (48) Services delivered to American Indians/Alaskan Natives (AI/AN) in ~~I/T/Us~~Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.
- (49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.
- (50) Residential substance use disorder (SUD) services.
- (51) Medication-assisted treatment (MAT) services.
- (52) Diabetes self-management education and support (DSMES).

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:

- (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
- (2) Services or any expense incurred for cosmetic surgery.
- (3) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
- (4) Refractions and visual aids.
- (5) Pre-operative care within ~~24~~twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
- (6) Sterilization of members who are under ~~24~~twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
- (7) Non-therapeutic hysterectomies.
- (8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. ~~(Refer to OAC 317:30-5-6 or 317:30-5-50.)~~
- (9) Medical services considered experimental or investigational. For more information regarding coverage of clinical trials, see Oklahoma Administrative Code (OAC) 317:30-3-57.1.
- (10) Services of a ~~Certified Surgical Assistant~~certified surgical assistant.

- (11) Services of a ~~Chiropractor~~chiropractor. Payment is made for ~~Chiropractor~~chiropractor services on ~~Crossover~~crossover claims for coinsurance and/or deductible only.
- (12) ~~Services of an independent licensed Physical and/or Occupational Therapist.~~Services of an independent licensed physical therapist and/or licensed physical therapist assistant. Per OAC 317:30-5-291.
- (13) Services of an independent licensed occupational therapist and/or occupational therapist assistant. Per OAC 317:30-5-296.
- ~~(13)~~(14) Services of a ~~Psychologist.~~psychologist.
- ~~(14)~~(15) Services of an independent licensed ~~Speech and Hearing Therapist.~~speech-language pathologist, speech-language pathology assistant (SLPA), and/or speech-language clinical fellow. Per OAC 317:30-5-675.
- ~~(15)~~(16) Payment for more than four (4) outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
- ~~(16)~~(17) Payment for more than ~~two nursing~~two (2) long-term care facility visits per month.
- ~~(17)~~(18) More than one (1) inpatient visit per day per physician.
- ~~(18)~~(19) Payment for removal of benign skin lesions.
- ~~(19)~~(20) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
- ~~(20)~~(21) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
- ~~(21)~~(22) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in ~~OHCA~~the Oklahoma Health Care Authority (OHCA) rules.
- ~~(22)~~(23) Mileage.
- ~~(23)~~(24) A routine hospital visit on the date of discharge unless the member expired.
- ~~(24)~~(25) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
- ~~(25) Inpatient chemical dependency treatment.~~
- (26) Fertility treatment.
- (27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
- ~~(28) Sleep studies.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.16. Related services

- (a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the ~~Authority's Medical Programs.~~SoonerCare program.
- (b) **Home health care.** ~~Hospital-based~~Hospital-based home health providers must be Medicare certified and have a current Home Health Agency contract with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). For home health services, a qualified provider must conduct and document a face-to-face encounter with the member in accordance with provisions of ~~42 CFR §440.70.~~42 Code

of Federal Regulations (C.F.R.) § 440.70. Refer to Oklahoma Administrative Code (OAC) 317:30-5-546 and OAC 317:30-5-547 for additional policy related to coverage and reimbursement for home health care services.

~~(1) Payment is made for home health services provided in a member's residence to all categorically needy individuals.~~

~~(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.~~

~~(3) Payment is made for standard medical supplies.~~

~~(4) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.~~

~~(5) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electrospinal orthosis systems (ESO).~~

~~(6) Payment may be made to home health agencies for prosthetic devices.~~

~~(A) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate.~~

~~(B) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.~~

~~(C) Sterile tracheotomy trays are covered.~~

~~(D) Payment is made for colostomy and urostomy bags and accessories.~~

~~(E) Payment is made for hyperalimentation, including supplements, supplies and equipment rental on behalf of persons having permanently inoperative internal body organ dysfunction. Information regarding the member's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached when requesting prior authorization.~~

~~(F) Payment is made for ventilator equipment and supplies when prior authorized.~~

~~(G) Payment for medical supplies, oxygen, and equipment is made when using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.~~

(c) Hospice Services. Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide

and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.

(2) Hospice care is available for two initial 90 day periods and an unlimited number of subsequent 60 day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services.

(3) Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the member is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.

(4) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-2(a)(2)] the following are excluded from coverage:

- (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
- (2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.
- (3) Reversal of sterilization procedures for the purposes of conception are not covered.
- (4) Medical services considered experimental or investigational. For more information regarding coverage of clinical trials, see OAC 317:30-3-57.1.
- (5) Payment for removal of benign skin lesions for adults.
- (6) Visual aids.
- (7) Charges incurred while the member is in a skilled nursing or swing bed.
- (8) ~~Sleep studies for adults.~~

PART 17. MEDICAL SUPPLIERS

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority (OHCA). The supplier must comply with all applicable ~~State and Federal~~state and federal laws. ~~Effective January 1, 2011, all~~All suppliers of ~~durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)~~medical supplies, equipment, and appliances must be accredited by a Medicare deemed accreditation organization for quality standards for ~~DMEPOS~~durable medical equipment (DME) suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or agency needs for SoonerCare members. Additionally, unless an exception is granted from the

OHCA, all ~~DMEPOS~~DME providers must meet the following criteria:

(1) ~~DMEPOS~~DME providers are required to have a physical location in the State of Oklahoma, or within a designated range of the Oklahoma State border, as determined by the OHCA. The OHCA may make exceptions to this requirement if a ~~DMEPOS~~DME provider provides a specialty item, product, or service, which is not otherwise available to SoonerCare members within the State of Oklahoma. Provider contracts for out-of-state ~~DMEPOS~~DME providers will be reviewed on a case-by-case basis for specialty items only. The OHCA has discretion and the final authority to approve or deny any provider contract.

(2) ~~DMEPOS~~DME providers are required to comply with Medicare ~~DMEPOS~~DME Supplier Standards for ~~DMEPOS~~medical supplies, equipment, and appliances provided to SoonerCare members, except the requirement to meet surety bond requirements, as specified in 42 C.F.R. Code of Federal Regulations (C.F.R.) § 424.57(c).

(3) Complex ~~Rehabilitation~~ ~~Technology~~rehabilitation technology (CRT) suppliers are considered ~~DMEPOS~~DME providers. Only CRT suppliers may bill CRT procedure codes. A CRT supplier means a company or entity that:

(A) Is accredited by a recognized accrediting organization as a supplier of CRT;

(B) Is an enrolled Medicare supplier and meets the supplier and quality standards established for DME suppliers, including those for CRT, under the Medicare program;

(C) Employs as a W-2 employee at least one (1) qualified CRT professional, also known as assistive technology professional, for each location to:

(i) Analyze the needs and capacities of complex-needs patients in consultation with qualified health care professionals;

(ii) Participate in selecting appropriate CRT items for such needs and capacities; and

(iii) Provide the complex-needs patient technology related training in the proper use and maintenance of the CRT items.

(D) Requires a qualified CRT professional be physically present for the evaluation and determination of the appropriate CRT;

(E) Has the capability to provide service and repair by qualified technicians for all CRT items it sells; and

(F) Provides written information to the complex-needs patient prior to ordering CRT as to how to access service and repair.

317:30-5-210.1. Coverage for adults

~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for adults is specified in OAC 317:30-5-211.1 through OAC 317:30-5-211.18.~~Coverage of medical supplies, equipment, and appliances for adults complies with 42 Code of Federal Regulations (C.F.R.) § 440.70 and is specified in Oklahoma Administrative Code (OAC) 317:30-5-211.1 through OAC 317:30-5-211.19.

317:30-5-210.2. Coverage for children

(a) **Coverage.** ~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for children includes the specified coverage for adults found in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. In addition the following are covered items for children only:~~Medical supplies, equipment, and appliances are covered for children.

(1) ~~Orthotics and prosthetics.~~

(2) ~~Enteral nutrition is considered medically necessary for certain conditions in which, without~~

the products, the member's condition would deteriorate to the point of severe malnutrition.

(A) Enteral nutrition must be prior authorized. PA requests must include:

(i) the member's diagnosis;

(ii) the impairment that prevents adequate nutrition by conventional means;

(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate;

(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and

(v) prescribed daily caloric intake.

(B) Enteral nutrition products that are administered orally and related supplies are not covered.

(3) Continuous positive airway pressure devices (CPAP).

(b) **EPSDT Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.**

Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized. EPSDT services, supplies, or equipment that are determined to be medically necessary for a child, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, are covered regardless of whether such services, supplies, or equipment are listed as covered in the Oklahoma Medicaid State Plan.

(c) **Medical necessity.** Federal regulations require ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental. For more information regarding clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

317:30-5-211.1. Definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise.

"Activities of daily living-basic" means a series of activities performed on a day-to-day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).

"Activities of daily living-instrumental" means activities that are not necessarily required on a daily basis but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).

"Adaptive equipment" means ~~devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for Individuals with Intellectual Disabilities (IFC/IID) with independence and safety.~~

"Basic activities of daily living" means a series of activities performed on a day to day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).

"Capped rental" means monthly payments for the use of the ~~Durable Medical Equipment (DME)~~medical supplies, equipment, and appliances for a limited period of time not to exceed ~~13~~thirteen (13) months. Items are considered purchased and owned by the Oklahoma Health Care

Authority (OHCA) after 13thirteen (13) months of continuous rental.

"Certificate of medical necessity (CMN)" means a certificate which is required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this Chapter. ~~The physician's certification~~ CMN must include the member's diagnosis, the reason the equipment is required, and the physician's, non-physician provider's (NPP's), or dentist's estimate, in months, of the duration of its need.

~~"Complex needs patient" means an individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.~~

"Complex rehabilitation technology" means medically necessary durable medical equipment and items that are individually configured to meet specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living of a ~~complex needs patient~~ member with complex needs. Such equipment and items include, but are not limited to, individually configured power wheelchairs and accessories, individually configured manual wheelchairs and accessories, adaptive seating and positioning systems and accessories, and other specialized equipment such as standing frames and gait trainers.

"Customized DMEequipment and/or appliances" means items of ~~DME~~ equipment and/or appliances which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician or other qualified medical professional. For instance, a wheelchair would be considered "customized" if it has been:

- (A) ~~measured~~ Measured, fitted, or adapted in consideration of the member's body size, disability, period of need, or intended use;
- (B) ~~assembled~~ Assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and
- (C) ~~intended~~ Intended for an individual member's use in accordance with instructions from the member's physician.

"Durable medical equipment (DME)Equipment and/or appliances" means ~~equipment that can withstand repeated use (e.g. a type of item that could normally be rented), is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting, including the home or workplace~~ items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, can be reusable or removable, and are suitable for use in any setting in which normal life activities take place other than a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Refer to 42 Code of Federal Regulations (C.F.R.) 440.70(b).

"Face-to-face encounter" means a patient visit in which a practitioner, as defined by 42 C.F.R. 440.70(f), completes a face-to-face assessment related to the primary reason the beneficiary requires durable medical equipment. The face-to-face encounter must occur no more than six (6) months prior to the start of services. The ordering physician must document the face-to-face encounter, including the practitioner who conducted the encounter and the date of the encounter. Clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record. The face-to-face encounter may occur through telehealth.

"Instrumental activities of daily living" means ~~activities that are not necessarily required on a daily basis, but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing~~

personal finances)-

"Invoice" means a document that provides the following information when applicable: the description of product, quantity, quantity in box, purchase price, NDC, strength, dosage, provider, seller's name and address, purchaser's name and address, and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"Medical supplies" means ~~an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers.~~ health care related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, that are required to address an individual medical disability, illness, or injury. Medical supplies do not include skin care creams, cleansers, surgical supplies, or medical or surgical equipment.

"OHCA CMN" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this ~~chapter~~ Chapter. The ~~physician's certification~~ CMN must include the member's diagnosis, the reason equipment is required, and the physician's, NPP's, or dentist's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one (1) has not been established by CMS.

"Orthotics" means ~~an item used for the correction or prevention of skeletal deformities.~~ a device used to support, align, prevent or correct deformities, protect a body function, improve the function of movable body parts or to assist a dysfunctional joint.

"Patient with complex needs" means an individual with a diagnosis or medical condition that results in significant loss of physical or functional needs and capacities.

~~"Prosthetic devices"~~ **"Prosthetics"** means ~~a replacement, corrective, or supportive device (including repair and replacement parts of the same) worn on or in the body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.~~ an artificial substitute which replaces all or part of a body organ or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

"Provider" refers to the treating provider and must be a physician [Medical Doctor (MD), or Doctor of Osteopathy, (DO)], a NPP [Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)], or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)].

~~"Qualified complex rehabilitation technology professional"~~ means ~~an individual who is certified as an Assistive Technology Professional (ATP) by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).~~

317:30-5-211.2. Medical necessity

(a) **Coverage.** Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member, in accordance with state and federal Medicaid law, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-1(f). The member's diagnosis must warrant the type of equipment or supply being purchased or rented. Items that are used for the following are not a benefit to a member of any age:

- (1) Routine personal hygiene;
- (2) Education;

- (3) Exercise;
- (4) Convenience, safety, or restraint of the member, or his or her family or caregiver;
- (5) Participation in sports; and/or
- (6) Cosmetic purposes.

(b) Ordering requirements. All medical supplies, equipment, and appliances as defined by 42 Code of Federal Regulations (C.F.R.) § 440.70 (b)(3) and OAC 317:30-5-211.1, nursing services, and home health aide services provided by a home health agency, must be ordered by a physician, nurse practitioner, clinical nurse specialist or physician assistant, working in accordance with State law, as part of a written plan of care.

(1) The plan of care must be reviewed in accordance with 42 C.F.R. § 440.70. Medical supplies, equipment, and appliances must be reviewed annually by the ordering provider. Nursing services and home health aide services provided by a home health agency must be reviewed every sixty (60) days by the ordering provider.

(2) A face-to-face encounter must occur and be documented, in accordance with 42 C.F.R. § 440.70 and OAC 317:30-5-211.1.

(b)(c) Prescription requirements. All ~~DME~~ medical supplies, equipment, and appliances, as those terms are defined by 42 C.F.R. § 440.120 and OAC 317:30-5-211.1, except for hearing aid batteries and equipment repairs with a cost per item of less than ~~\$250.00~~ \$1,000.00 total parts and labor ~~and hearing aid batteries~~, require a prescription signed by a physician, a physician assistant, or an advanced practice registered nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one (1) year from the date written. The prescription must include the following information:

- (1) date of the order;
- (2) name and address of the prescriber;
- (3) name and address of the member;
- (4) name or description and quantity of the prescribed item;
- (5) diagnosis for the item requested;
- (6) directions for use of the prescribed item; and
- (7) prescriber's signature.

(1) The member's name;

(2) The prescribing practitioner's name;

(3) The date of the prescription;

(4) All items, options, or additional features that are separately billed. The description can be either a narrative description (e.g., lightweight wheelchair base), a Healthcare Common Procedure Coding System (HCPCS) code, a HCPCS code narrative, or a brand name/model number; and

(5) The prescribing practitioner's signature and signature date.

(e)(d) Certificate of medical necessity (CMN). For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician, non-physician practitioner, or dentist. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be ~~faxed, copied~~ faxed copy, electronic copy, or the original hardcopy.

(d)(e) Place of service.

(1) OHCA covers DMEPOS for use in the member's place of residence except if the member's place of residence is a nursing facility. The Oklahoma Health Care Authority (OHCA) covers

medical supplies, equipment, and appliances for use in the member's place of residence and in any setting in which normal life activities take place except for a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

~~(2) For members residing in a nursing facility, most medical supplies and/or DME are considered part of the facility's per diem rate. Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.~~ For members residing in a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board, medical supplies, equipment, and appliances are considered part of the facility's per diem rate.

(f) **Contracting requirements.** Per 42 C.F.R. 455.410(b), medical supplies, equipment, and appliances may only be ordered or prescribed by a SoonerCare contracted provider.

317:30-5-211.3. Prior authorization (PA)

(a) **General.** ~~Prior authorization~~ PA is the electronic or written authorization issued by ~~OHCA~~ the Oklahoma Health Care Authority (OHCA) to a provider prior to the provision of a service. Providers should obtain a PA before providing services.

(b) **Requirements.** Billing must follow correct coding guidelines as promulgated by ~~CMS~~ the Centers for Medicare and Medicaid Services (CMS) or per uniquely and publicly promulgated OHCA guidelines. ~~DME~~ Medical supplies, equipment, and appliances claims must include the most appropriate ~~HCPCS~~ Healthcare Common Procedure Coding System (HCPCS) code as assigned by the Medicare Pricing, Data, Analysis, and Coding (PDAC) or its successor. Authorizations for services not properly coded will be denied. ~~The following services require prior authorization (PA):~~ The following services require PA:

- (1) ~~services~~ Services that exceed quantity/frequency limits;
- (2) ~~medical~~ Medical need for an item that is beyond OHCA's standards of coverage;
- (3) ~~use~~ Use of a Not Otherwise Classified (NOC) code or miscellaneous codes;
- (4) ~~services~~ Services for which a less costly alternative may exist; and
- (5) ~~procedures~~ Procedures indicating that a PA is required on the OHCA fee schedule.

(c) ~~Prior authorization (PA)~~ PA requests. Refer to OAC 317:30-5-216.

(1) **PA requirements.** Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring a PA. Also refer to OAC 317:30-3-31.

(A) **Required forms.** All required forms are available on the OHCA website.

(B) **Certificate of medical necessity (CMN).** The prescribing physician, non-physician practitioner (NPP), or dentist must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's physician, NPP, or dentist may sign the CMN. By signing the CMN, the physician, NPP, or dentist is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the PA

request.

(2) **Submitting PA requests.** Contact information for submitting PA requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA website.

(3) **PA review.** Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(4) **PA decisions.** After the PA request is processed, a notice will be issued regarding the outcome of the review.

(5) **PA does not guarantee reimbursement.** Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.

(6) **PA of manually-priced items.** Manually-priced items must be prior authorized. For reimbursement of manually priced items, see OAC 317:30-5-218.

317:30-5-211.5. Repairs, maintenance, replacement and delivery

(a) **Repairs.** Repairs to equipment that either the Oklahoma Health Care Authority (OHCA) or a member owns are covered when they are necessary to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment cannot be made for the amount in excess. Repairs of rented equipment are not covered.

(b) **Maintenance.** Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service. ~~DMEPOS~~DME suppliers must provide equipment-related services consistent with the manufacturer's specifications and in accordance with all federal, state, and local laws and regulations. Equipment-related services may include, but are not limited to, checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms and back-up systems. However, more extensive maintenance, as recommended by the manufacturer and performed by authorized technicians, is considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a capped rental item that supplied the item the ~~13th~~thirteenth (13th) month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) **Replacement.**

~~(1) If a capped rental item of equipment has been in continuous use~~If equipment that has met the capped rental period and has been in continued use by the member for the equipment's useful life or if the item is irreparably damaged, lost, or stolen, a prior authorization must be submitted to obtain new equipment. The reasonable useful lifetime for capped rental equipment cannot be less than five (5) years. Useful life is determined by the delivery of the equipment to the member, not the age of the equipment.

(2) Replacement parts must be billed with the appropriate ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) code that represents the item or part being ~~replaced along~~replaced along with a pricing modifier and replacement modifier. If a part that

has not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item, and an invoice.

(d) **Delivery.** DMEPOS Medical supplies, equipment, and appliance products are set with usual maximum quantities and frequency limits. Suppliers are not expected to provide these amounts routinely, nor are members required to accept DMEPOS medical supplies, equipment, and appliance products at frequencies or in quantities that exceed the amount the member would typically use. Suppliers must not dispense a quantity of any DMEPOS medical supplies, equipment, and appliance product exceeding a member's expected utilization. The reordering or refilling of DMEPOS medical supplies, equipment, and appliance products should always be based on actual member usage. Suppliers should stay attuned to atypical utilization patterns on behalf of their members and verify with the ordering physician that the atypical utilization is warranted. Suppliers must exercise the following guidelines in regard to the delivery of DMEPOS medical supplies, equipment, and appliance products:

(1) For DMEPOS medical supplies, equipment, and appliance products that are supplied as refills to the original order, suppliers must contact the member prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the member regarding refills should take place no sooner than ~~7~~ seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier must deliver the DMEPOS medical supplies, equipment, and appliance product no sooner than ~~5~~ five (5) days prior to the end of the usage for the current product. This is regardless of which delivery method is utilized. A member must specifically request the refill before a supplier dispenses the product. Suppliers must not automatically dispense a quantity of supplies on a predetermined basis, even if the member has authorized this in advance. The supplier must have member contact documentation on file to substantiate that the DMEPOS medical supplies, equipment, and appliance product was refilled in accordance with this section.

(2) For DMEPOS medical supplies, equipment, and appliance products that are supplied via mail order, suppliers must bill using the appropriate modifier which indicates that the DMEPOS medical supplies, equipment, and appliance product was delivered via the mail. Reimbursement for DMEPOS medical supplies, equipment, and appliance products supplied and delivered via mail may be at a reduced rate.

(3) For DMEPOS medical supplies, equipment, and appliance products that are covered in the scope of the SoonerCare program, the cost of delivery is always included in the rate for the covered item(s).

317:30-5-211.6. General documentation requirements

(a) Section 1833(e) of the Social Security Act precludes payment to any provider of service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" [~~42 U.S.S. Section 13951(e)~~][42 United States Code (U.S.C.) Section 13951(e)]. The member's medical records will reflect the need for the care provided. The member's medical records should include the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be provided for prior authorization requests and available to the OHCA Oklahoma Health Care Authority (OHCA) or its designated agent upon request.

(b) Payment is made for durable medical equipment as set forth in this section when a face-to-face encounter has occurred in accordance with provisions of 42 Code of Federal Regulations (C.F.R.) § 440.70 and Oklahoma Administrative Code (OAC) 317:30-5-211.1.

317:30-5-211.9. Adaptive equipment [REVOKED]

~~(a) **Residents of ICF/IID facilities.** Payment is made for customized adaptive equipment for persons residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). This means customized equipment or devices to assist in ambulation. Standard wheelchairs, walkers, eyeglasses, etc., would not be considered customized adaptive equipment. All customized adaptive equipment must be prescribed by a physician and requires prior authorization.~~

~~(b) **Members in home and community-based waivers.** Refer to OAC 317:40-5-100.~~

317:30-5-211.10. Durable medical equipment (DME) Medical supplies, equipment, and appliances

~~(a) **DME Medical supplies, equipment, and appliances.** DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment, and other qualifying items when acquired from a contracted DME provider. See the definition for medical supplies, equipment, and appliances at Oklahoma Administrative Code (OAC) 317:30-5-211.1.~~

~~(b) **Certificate of medical necessity (CMN).** Certain items of ~~DME~~ medical supplies, equipment, and appliances require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include, but are not limited to:~~

- ~~(1) hospital beds;~~
- ~~(2) support surfaces;~~
- ~~(3) patient lift devices;~~
- ~~(4) external infusions pumps;~~
- ~~(5) enteral and parenteral nutrition;~~
- ~~(6) Oxygen and oxygen related products; and~~
- ~~(7) pneumatic compression devices.~~

- (1) External infusion pumps;
- (2) Hospital beds;
- (3) Oxygen and oxygen related products;
- (4) Pneumatic compression devices;
- (5) Support surfaces;
- (6) Enteral and parenteral nutrition; and
- (7) Osteogenesis stimulator.

~~(c) **Prior authorization-Rental.** Several medical supplies, equipment, and appliance products are classified as either a capped rental or a continuous rental. Payment for a capped rental is capped at thirteen (13) months and a continuous rental is paid monthly for as long as it is medically necessary. Both require documentation showing that the product is medically necessary.~~

~~(1) **Rental.** Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and, except for CPAP and BiPAP devices, a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record, signed by the physician, and attached to the PA.~~

~~(2) **Purchase.** Equipment may be purchased when a member requires the equipment for an extended period of time. During the prior authorization review, the OHCA may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.~~

(d) **Purchase.** Medical supplies, equipment, and appliances may be purchased when a member requires the product for an extended period of time. During the prior authorization review, the Oklahoma Health Care Authority (OHCA) may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted.

~~(d)(e) **Backup equipment.** Backup equipment is considered part of the rental cost and is not a covered service without prior authorization.~~

(e)(f) **Home modification.** Equipment used for home modification is not a covered service. Home modifications that require permanent installation are not covered services as they are not removable and therefore do not meet the definition of medical supplies, equipment, and appliances per 42 Code of Federal Regulations (C.F.R.) § 440.70. Refer to Title 317, Chapters 40 and 50 for home modifications covered under Home and Community Based Services Waivers, including the ADvantage Waiver.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc., that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) Stationary oxygen systems and portable oxygen systems are covered items for members residing in their home ~~or in a nursing facility~~ and in any setting in which normal life activities take place except for a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. ~~Portable oxygen contents are not covered for adults. Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment.~~ The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.

(3) When four ~~(4)~~ or more liters of oxygen are medically necessary, an additional payment will be paid up to ~~450%~~ one hundred and fifty percent (150%) of the allowable for a stationary system when billed with the appropriate modifier.

317:30-5-211.13. ~~Prosthetics and orthotics~~ Orthotics and prosthetics

(a) Coverage of prosthetics for ~~adults~~ non-expansion adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. Prosthetics prescribed by an appropriate ~~medical~~ qualified provider and as specified in this section are covered items for ~~adults~~ non-expansion adults. There is no coverage of orthotics for ~~adults~~ non-expansion adults.

(1) **Home dialysis.** Equipment and supplies are covered items for members receiving home

dialysis treatments only.

(2) **Nerve stimulators.** Payment is made for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators.

(3) **Breast prosthesis, bras, and prosthetic garments.**

(A) Payment is limited to:

(i) ~~one~~ One (1) prosthetic garment with mastectomy form every ~~12~~ twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) ~~two~~ Two (2) mastectomy bras per year; and

(iii) ~~one~~ One (1) silicone or equal breast prosthetic per side every ~~24~~ twenty-four (24) months; or

(iv) ~~one~~ One (1) foam prosthetic per side every six (6) months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same ~~12~~ twelve (12) month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) ~~lost~~ Lost;

(ii) ~~irreparably~~ Irreparable damaged (other than ordinary wear and tear); or

(iii) ~~the~~ The member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

(4) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(b) Orthotics and prosthetics are covered for expansion adults services when:

(1) Orthotics are medically necessary when required to correct or prevent skeletal deformities, to support or align movable body parts, or to preserve or improve physical function.

(2) Prosthetics are medically necessary as a replacement for all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The member shall require the prosthesis for mobility, daily care, or rehabilitation purposes.

(3) In addition, orthotics and prosthetics must be:

(A) A reasonable and medically necessary part of the member's treatment plan;

(B) Consistent with the member's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the member; and

(C) Of high quality, with replacement parts available and obtainable.

(c) Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.

317:30-5-211.14. Nutritional support

(a) **Enteral nutrition.** Enteral nutrition administered only via gravity, syringe, or pump is covered

for children and adults at home. Refer to pharmacy policy related to coverage of food supplements at Oklahoma Administrative Code (OAC) 317:30-5-72.1(2)(C). For enteral nutrition authorization guidelines, see OAC 317:30-5-211.20.

~~(a)~~**(b) Parenteral nutrition.** The member must require intravenous feedings to maintain weight and strength commensurate with the member's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

(1) The member must have a permanent impairment. Permanence does not require a determination that there is no possibility that the member's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three (3) months), the test of permanence is met. Parenteral nutrition will be denied as a non-covered service in situations involving temporary impairments.

(2) The member must have a condition involving the small intestine, exocrine glands, or other conditions that significantly impair the absorption of nutrients. Coverage is also provided for a disease of the stomach and/or intestine that is a motility disorder and impairs the ability of nutrients to be transported through the GI system, and other conditions as deemed medically necessary. There must be objective medical evidence supporting the clinical diagnosis.

(3) Re-certification of parenteral nutrition will be required as medically necessary and determined by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) medical staff.

(c) Long-term care facility enteral and parenteral nutrition. Enteral and parenteral nutrition products supplied to long-term care facility residents are included in the long-term care facility per diem rate.

~~(b)~~**(d) ~~Prior authorization~~Claim submission requirements.** A written signed and dated order must be received by the supplier before a claim is submitted to the OHCA. If the supplier bills an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary. The ordering physician is expected to see the member within ~~30~~thirty (30) days prior to the initial certification or required re-certification. If the physician does not see the member within this time frame, the physician must document the reason why and describe what other monitoring methods were used to evaluate the member's parenteral nutrition needs.

~~(e) Enteral formulas.~~ ~~Enteral formulas are covered for children only. See OAC 317:30-5-210.2.~~

317:30-5-211.15. SuppliesMedical Supplies

The ~~OHCA~~Oklahoma Health Care Authority (OHCA) provides coverage for medically necessary supplies that are prescribed by the appropriate medical provider and meet the ~~special requirements below:~~member's specific needs. Medical supplies include, but are not limited to, IV therapy supplies, diabetic supplies, catheters, colostomy and urostomy supplies, and incontinence supplies.

~~(1) Intravenous therapy.~~ ~~Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.~~

~~(2) Diabetic supplies.~~ ~~Glucose test strips and lancets are covered when medically necessary and prescribed by a physician, physician assistant, or an advanced practice nurse. Testing supplies may be limited based on insulin use or type of diabetes. Prior authorization may be required for supplies beyond the standard allowance.~~

~~(3) Catheters.~~ ~~Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must~~

~~indicate such documentation is available in the member's medical record.~~

~~(4) **Colostomy and urostomy supplies.** Colostomy and urostomy bags and accessories are covered items.~~

317:30-5-211.16. Coverage for nursing long-term care facility residents

~~(a) For residents in a nursing long-term care facility, ~~most DMEPOS medical supplies, equipment and appliances~~ are ~~considered part of~~ included in the facility's per diem rate. Orthotics and prosthetics are paid separately from the per diem rate in accordance with the Oklahoma Medicaid State Plan. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.13 for orthotics and prosthetics coverage. The following are not included in the per diem rate and may be billed by the appropriate medical supplier:~~

~~(1) Services requiring prior authorization:~~

~~(A) ventilators and supplies;~~

~~(B) total parenteral nutrition (TPN), and supplies;~~

~~(C) custom seating for wheelchairs; and~~

~~(D) external breast prosthesis and support accessories.~~

~~(2) Services not requiring prior authorization:~~

~~(A) permanent indwelling or male external catheters and catheter accessories;~~

~~(B) colostomy and urostomy supplies;~~

~~(C) tracheostomy supplies;~~

~~(D) catheters and catheter accessories;~~

~~(E) oxygen and oxygen concentrators.~~

~~(i) **PRN oxygen.** Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~

~~(ii) **Billing for Medicare eligible nursing home members.** Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.~~

~~(b) Items not covered include but are not limited to:~~

~~(1) diapers;~~

~~(2) underpads;~~

~~(3) medicine cups;~~

~~(4) eating utensils; and~~

~~(5) personal comfort items.~~

317:30-5-211.17. Wheelchairs

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) "**Assistive technology professional**" or "**ATP**" means a for-service provider who is involved in analysis of the needs and training of a consumer in the use of a particular assistive technology device or is involved in the sale and service of rehabilitation equipment or commercially available assistive technology products and devices. All ATPs are required to be credentialed by Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(2) "**Custom seating system**" means a wheelchair seating system which is individually made for a member using a plaster model of the member, a ~~computer-generated~~ computer-generated model of the member (e.g., CAD-CAM technology), or the detailed measurements of the

member to create either:

(A) ~~a~~A molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or

(B) ~~a~~A custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not be easily re-adapted for use by another individual.

~~(3) "RESNA" means the Rehabilitation Engineering and Assistive Technology Society of North America.~~

~~(4)~~(3) "**Specialty evaluation**" means the determination and documentation of the consumer's pathology, history and prognosis, and the physiological, functional, and environmental factors that impact the selection of an appropriate wheeled mobility system.

(b) **Medical Necessity.** Medical necessity, pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-211.2, is required for a wheelchair to be covered and reimbursed by SoonerCare. Only one (1) wheelchair is covered as medically necessary during its reasonable useful lifetime, unless the member's documented medical condition indicates the current wheelchair no longer meets the member's medical need. Backup wheelchairs are not covered items.

(c) **Prior authorization.** Prior authorization, pursuant to OAC 317:30-5-211.3, is required for selected wheelchairs to be covered and reimbursed by SoonerCare. All prior authorization requests for the purchase of a wheelchair must indicate the length of the warranty period and what is covered under the warranty.

(1) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the member to perform leisure or recreational activities are not considered medically necessary and will not be authorized.

(2) Wheelchair parts, accessories, and/or modifications that are distinctly and separately requested and priced from the original wheelchair request may require prior authorization.

(3) The ~~OHCA~~Oklahoma Health Care Authority will deny prior authorization requests when the required forms have not been fully completed or the member's medical record does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.

(d) **Coverage and limitations.**

~~(1) For a member who resides in a personal residence, assisted living facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or long term care facility, the following criteria must be met for the authorization to purchase a wheelchair.~~

~~(A) The member must have a prescription signed by a physician, a physician assistant, or an advanced registered nurse practitioner.~~

~~(B) The member must meet the requirements for medical necessity as determined and approved by the OHCA.~~

~~(C) The member must either have:~~

~~(i) a specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist, occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations, and that documents the medical necessity for the wheelchair and its special features; or~~

~~(ii) a wheelchair provided by a supplier that employs a RESNA certified assistive technology professional who specializes in wheelchairs and who has direct, in-~~

person involvement in the wheelchair selection for the member.

~~(2) For members who reside in a long-term care facility or ICF/IID, only custom seating systems for wheelchairs are eligible for direct reimbursement to DME providers. For members who reside in a long-term care facility or intermediate care facility for individuals with intellectual disabilities, All standard manual and power wheelchairs are the responsibility of the facility and are considered part of the facility's per diem rate. Repairs and maintenance, except for custom seating systems, are not covered items for wheelchairs and are considered part of the facility's per diem rate.~~

(e) **Rental, repairs, maintenance, and delivery.** Refer to OAC 317:30-5-211.4 through 317:30-5-211.5.

(f) **Documentation.**

(1) The specialty evaluation or wheelchair selection documentation must be submitted with the prior authorization request.

(2) The specialty evaluation or wheelchair selection must be performed no longer than ~~90~~ninety (90) days prior to the submission of the prior authorization request.

(3) The results of the specialty evaluation or wheelchair selection documentation must be supported by the information submitted on the member's medical record.

(4) A copy of the dated and signed written specialty evaluation or wheelchair selection document must be maintained by the wheelchair provider. The results of the specialty evaluation or wheelchair selection must be written, signed, and dated by the medical professional who evaluated the member or the ATP who was involved in the wheelchair selection for the member.

317:30-5-211.20. Enteral nutrition

(a) Enteral nutrition. Enteral nutrition is the delivery of nutrients directly into the stomach, duodenum, or jejunum.

(b) Medical necessity. Enteral nutrition supplies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. Requests by qualified providers for enteral nutrition supplies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) Documentation. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

(1) Diagnosis;

(2) Certificate of medical necessity (CMN);

(3) Ratio data;

(4) Route;

(5) Caloric intake; and

(6) Prescription.

(7) For full guidelines, please refer to www.okhca.org/mau.

(d) Reimbursement.

(1) Extension sets and Farrell bags are not covered when requested separately from the supply kits;

(2) Enteral nutrition for individuals in long-term care facilities is not separately reimbursed as

this is included in the per diem rate.

(e) **Non-covered items.** The following are non-covered items:

- (1) Orally administered enteral products and/or related supplies;
- (2) Formulas that do not require a prescription unless administered by tube;
- (3) Food thickeners, human breast milk, and infant formula;
- (4) Pudding and food bars; and
- (5) Nursing services to administer or monitor the feedings of enteral nutrition.

317:30-5-211.21. Incontinence supplies

(a) **Incontinence supplies and services.** Incontinence supplies and services are those supplies that are used to alleviate or prevent skin breakdown or excoriation associated with incontinence.

(b) **Medical necessity.** Incontinence supplies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for incontinence supplies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

- (1) A signed prescription by a provider specifying the requested item;
- (2) A documented diagnosis of an underlying chronic medical condition that involves loss of bladder or bowel control;
- (3) Documentation must include the height and weight of the member, the type of incontinence (bowel/bladder/combined), and expected length of need;
- (4) Requests submitted for underwear/pull-on(s) the member must be ambulatory or in toilet training;
- (5) The member may qualify for incontinence supplies for a short period of time when the member has documented full-skin thickness injuries;
- (6) When requesting wipes as incontinence supplies, documentation must be submitted specific to the supply being requested. Disposable wipes are only allowed when diapers have been approved;
- (7) For full guidelines, please refer to www.okhca.org/mau.

(d) **Quantity limits.** There is a quantity limit to the products allowed as well as product combinations. For a listing of quantity limits on specific products, refer to the OHCA website, under the Durable Medical Equipment page, "Incontinence Supplies". Requests for quantities or combinations outside of the limits published will require additional medical review for approval.

(e) **Non-covered items.** The following are non-covered items:

- (1) Incontinence supplies for members under the age of four (4) years;
- (2) Reusable underwear and/or reusable pull-ons;
- (3) Reusable briefs and/or reusable diapers;
- (4) Diaper service for reusable diapers;
- (5) Feminine hygiene products;
- (6) Disposable penile wraps; and
- (7) Shipping costs.

317:30-5-211.22. Pulse oximeter

(a) Pulse oximeter. Pulse oximeter is a device used for measuring blood oxygen levels in a non-invasive manner.

(b) Medical necessity. Pulse oximeters must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for pulse oximeters in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) Documentation. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

(1) A current oxygen order signed and dated by an OHCA-contracted provider, along with a certificate of medical necessity (CMN);

(2) Pertinent information relating to the member's underlying diagnosis and condition which results in the need for the oximeter and supplies, including documentation of unstable airway events and documentation of current monitor readings if available; and

(3) Documentation of an available trained caregiver in the home who is able to intervene and address changes in the member's oxygen saturation levels in a medically safe and appropriate manner.

(4) For full guidelines, please refer to www.okhca.org/mau.

(d) Reimbursement.

(1) Temporary probe covers are not reimbursed separately for rented oximeters as they are included in the price of the rental.

(2) Pulse oximeters are not reimbursed in conjunction with apnea monitors.

317:30-5-211.23. Continuous passive motion device for the knee

(a) Continuous passive motion (CPM). CPM is a postoperative treatment method designed to aid recovery of joint range of motion after joint surgery. CPM provides for early post-operative motion and is considered a substitute for active physical therapy (PT).

(b) Medical necessity. CPM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for CPM in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(1) A knee CPM device is covered for up to twenty-one (21) days and does not require a prior authorization (PA) for a patient in an early phase of rehabilitation.

(2) A knee CPM device required for more than twenty-one (21) days does require a PA of the additional days. These cases will be individually reviewed for medical necessity.

(c) Documentation. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Documentation must include:

(A) Type of surgery performed;

(B) Date of surgery;

(C) Date of application of CPM;

(D) Date of discharge from the hospital; and

(E) Written prescription issued by a licensed prescriber that is signed and dated no more than thirty (30) days prior to the first date of service and that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.

(2) For full guidelines, please refer to www.okhca.org/mau.

(d) Reimbursement.

(1) Separate reimbursement will not be made for use of device while member is hospitalized or in a long-term care facility.

(2) Billing for dates of service when the patient is no longer actively using the CPM device is not appropriate and is not reimbursable.

317:30-5-211.24. Parenteral nutrition

(a) **Parenteral nutrition (PN).** PN is the provision of nutritional requirements intravenously.

(b) **Medical necessity.** PN must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for PN in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Hospital records that have objective medical evidence supporting the clinical diagnosis; if applicable;

(2) A certificate of medical necessity;

(3) A prescription; and

(4) Caloric Intake.

(5) For full guidelines, please refer to www.okhca.org/mau.

(d) Reimbursement.

(1) Supply kits are all inclusive, unbundled supplies (e.g., gloves, tubing, etc.) are not reimbursable for PN.

(2) Pumps are rented as a capped rental.

317:30-5-211.25. Continuous glucose monitoring

(a) **Continuous glucose monitoring (CGM).** CGM means a minimally invasive system that measures glucose levels in subcutaneous or interstitial fluid. CGM provides blood glucose levels and can help members make more informed management decisions throughout the day.

(b) **Medical necessity.** CGM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for CGM in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity. CGM devices must be approved by the U.S. Food and Drug Administration (FDA) as non-adjunctive and must be used for therapeutic

purposes. Devices may only be used for members within the age range for which the devices have been FDA approved.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Requests for CGM must include all of the following documentation:

- (1) Prescription by a qualified provider;
- (2) Member diagnosis that correlates to the use of CGM;
- (3) Documentation of the member testing to include the frequency each day;
- (4) Documentation member is insulin-treated to include frequency of daily or is using insulin pump therapy;
- (5) Documentation member's insulin treatment regimen requires frequent adjustment;
- (6) The member and/or family member has participated in age appropriate diabetes education, training, and support prior to beginning CGM; and
- (7) In-person or telehealth visit [within the last six (6) months] between the treating provider, member and/or family to evaluate their diabetes control.
- (8) For full guidelines please refer to www.okhca.org/mau.

317:30-5-211.26. Bathroom equipment

(a) **Bathroom equipment.** Bathroom equipment is used for bathing and toileting and may be considered primarily medical in nature if used in the presence of an illness and/or injury and if it is necessary for activities of daily living that are considered to be essential to health and personal hygiene.

(b) **Medical necessity.** Bathroom equipment must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for bathroom equipment in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

- (1) Current written prescription for specific medical supply, equipment, and appliance item;
- (2) Letter of medical necessity;
- (3) Product information;
- (4) Manufacturer's suggested retail price (MSRP) for each item requested
- (5) For full guidelines, please refer to www.okhca.org/mau.

317:30-5-211.27. Positive airway pressure (PAP) devices

(a) **PAP devices.** PAP devices are both a single level continuous positive airway pressure device (CPAP), and/or a bi-level respiratory assist device with or without back-up rate when it is used in the treatment of obstructive sleep apnea.

(b) **Medical Necessity.** PAP devices must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for PAP devices in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority

pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

- (1) A face-to-face clinical evaluation by the treating qualified medical professional within six (6) months prior to receiving device;
- (2) Qualifying polysomnogram that is dated within one (1) year of the prior authorization request submission;
- (3) The patient and/or his or her caretaker have received instruction from the supplier of the device in the proper use and care of the equipment; and
- (4) Medical records supporting the need for a PAP device.
- (5) For full guidelines, please refer to www.okhca.org/mau.

317:30-5-211.28. Sleep studies

(a) **Sleep studies.** Sleep studies are the continuous and simultaneous monitoring and recording of specified physiological and pathophysiological parameters during a period of sleep for six (6) or more hours. The study is used to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP). A sleep study requires physician review, interpretation, and report.

(b) **Medical necessity.** Sleep studies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for sleep studies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation requirements include:

- (1) Legible signature of the qualified provider or non-physician practitioner responsible for and providing the care to the patient;
- (2) All pages in the prior authorization request must be clear and legible;
- (3) Face-to-face evaluation by the ordering provider, the supervising physician, or the interpreting physician; and
- (4) Medical records to support the medical indication for the sleep study including results of sleep scale.
- (5) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

- (1) Sleep studies for children must be performed in a sleep diagnostic testing facility to be reimbursable.
- (2) Sleep studies for adults age twenty-one (21) and older must be performed in a sleep diagnostic testing facility or as a home sleep study to be reimbursable.
- (3) A split study beginning on a given date with the titration beginning after midnight on the subsequent date is one (1) study and may not be billed as two (2) consecutive studies.

317:30-5-216. Prior authorization requests [REVOKED]

~~(a) **Prior authorization requirements.** Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring PA.~~

~~(1) **Required forms.** All required forms are available on the OHCA web site at www.okhea.org.~~

~~(2) **Certificate of medical necessity.** The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the prior authorization request.~~

~~(b) **Submitting prior authorization requests.** Contact information for submitting prior authorization requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA web site.~~

~~(c) **Prior authorization review.** Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.~~

~~(d) **Prior authorization decisions.** After the PA request is processed, a notice will be issued regarding the outcome of the review. If the request is approved the notice will include an authorization number, the appropriate date span and procedure codes approved.~~

~~(e) **Prior authorization does not guarantee reimbursement.** Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.~~

~~(f) **Prior authorization of manually priced items.** Manually priced items must be prior authorized. If manual pricing is used, the provider is reimbursed at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus 30% or invoice cost plus 30%, whichever is the lesser of two. OHCA may establish a fair market price through claims review and analysis.~~

317:30-5-218. Reimbursement

~~(a) **Medical equipment and supplies, equipment and appliances.**~~

~~(1) Reimbursement for durable medical equipment and supplies medical supplies, equipment, and appliances will be made using an amount derived from the lesser of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established. ~~The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~~~

~~(2) The fee schedule will be reviewed annually. Adjustments to the fee schedule may be possible at any time based on efficiency, budget considerations, federal regulations, and quality of care as determined by the OHCA.~~

~~(3) Payment for medical supplies, equipment, and appliances will be calculated using the rate~~

methodologies found in the Oklahoma Medicaid State Plan.

(4) Payment is not made for medical supplies, equipment, and appliances that are not deemed as medically necessary or considered over-the-counter.

(5) OHCA does not reimburse medical supplies, equipment, and appliances providers separately for services that are included as part of the payment for another treatment program. For example, all items required during inpatient stays are paid through the inpatient payment structure.

(6) Medical supplies, equipment, and appliance products purchased at a pharmacy are paid the equivalent to Medicare Part B, average sales price (ASP) + six percent (6%). When ASP is not available, an equivalent price is calculated using wholesale acquisition cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost.

(b) Manually-priced medical equipment and supplies. There may be instances when manual pricing is required. When it is, the following pricing methods will be used:

(1) Invoice pricing. Reimbursement is at the provider's documented manufacturer's suggested retail price (MSRP) minus thirty percent (30%) or at the provider's invoice cost plus thirty percent (30%), whichever is the lesser of the two.

(2) Fair market pricing. OHCA may establish a fair market price through claims review and analysis. For a list of medical equipment and supplies that are fair market-priced, refer to the OHCA website at www.okhca.org for the fair market value list (Selected medical supplies, equipment, and appliance items priced at fair market price).

(b)(c) Oxygen equipment and supplies.

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment that is made as long as it is medically necessary. The rental payment includes all contents and supplies, e.g., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to ~~pick up~~ pick up the equipment when it is no longer medically necessary. In addition, the provider/supplier will not be reimbursed for mileage.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~

(4) For residents in a long-term care facility, durable medical equipment products, including oxygen, are included in the facility's per diem rate.

PART 61. HOME HEALTH AGENCIES

317:30-5-545. Eligible providers

All eligible home health service providers must be Medicare certified, ~~accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO)~~, or have deemed status with Medicare, and have a current contract with the Oklahoma Health Care Authority (OHCA). Home ~~Health Agencies~~ health agencies billing for ~~durable medical equipment (DME)~~ medical supplies, equipment, and appliances must have a supplier contract and bill equipment on claim form CMS-

1500. Additionally, home health services providers that did not participate in Medicaid prior to January 1, 1998, must meet the "Capitalization Requirements" set forth in ~~42 CFR 489.28~~ Code of Federal Regulations (C.F.R.) § 489.28. Home health services providers that do not meet these requirements will not be permitted to participate in the Medicaid program.

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this section when a ~~face-to-face~~ face-to-face encounter has occurred in accordance with provisions of ~~42 CFR 440.70~~ Code of Federal Regulations (C.F.R.) § 440.70. Payment is made for home health services provided by a home health agency in the member's residence and in any setting in which normal life activities take place except for a hospital, long-term care facility, or intermediate care facility for individuals with intellectual disabilities. For individuals eligible for Part B of Medicare, payment is made utilizing the Medicaid allowable for comparable services.

~~(1) **Adults.** Payment is made for home health services provided in the member's residence to all categorically needy individuals. Coverage for adults is as follows.~~

~~(A) **Covered items.**~~

- ~~(i) Part-time or intermittent nursing services;~~
- ~~(ii) Home health aide services;~~
- ~~(iii) Standard medical supplies;~~
- ~~(iv) Durable medical equipment (DME) and appliances; and~~
- ~~(v) Items classified as prosthetic devices.~~

~~(B) **Non-covered items.** The following are not covered:~~

- ~~(i) Sales tax;~~
- ~~(ii) Enteral therapy and nutritional supplies;~~
- ~~(iii) Electro-spinal orthosis system (ESO); and~~
- ~~(iv) Physical therapy, occupational therapy, speech pathology, or audiological services.~~

~~(2) **Children.** Home Health Services are covered for persons under age 21.~~

~~(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.~~

317:30-5-547. Reimbursement

(a) Nursing services and home health aide services are covered services on a per visit basis. ~~Reimbursement for any combination of nursing or home aid service shall not exceed 36 visits per calendar year per member. Additional visits for children must be prior authorized when medically necessary. Thirty-six (36) visits per calendar year of nursing and/or home health aide services for any member do not require prior authorization; however, any visit surpassing the thirty-sixth (36) visit will require prior authorization and medical review.~~

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the ~~OHCA~~ Oklahoma Health Care Authority (OHCA) fee schedule or the provider's usual and customary charge. ~~The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure code.~~ When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to ~~pick up~~pick up the equipment when it is no longer medically necessary.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate.~~ The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

(4) Physical therapy, occupational therapy, and/or speech pathology and audiology services, are not covered when provided by a home health agency.

317:30-5-548. Procedure codes

~~Procedure codes for home health services are assigned HCPCS codes for supplies and durable medical equipment.~~ All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.

317:30-5-549. Prosthetic devices [REVOKED]

~~Payment may be made to home health agencies for prosthetic devices. Refer to the Medical Suppliers Provider Rules for further information.~~

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is ~~an~~ an SSA/SSI recipient in current payment status (including presumptive eligibility), a ~~TANF~~ Temporary Assistance for Needy Families (TANF) recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age nineteen (19), categorical relationship is automatically established. For individuals related to expansion adults the categorical relationship is established and defined by 42 Code of Federal Regulations (C.F.R.) § 435.119. Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. ~~Effective January 1, 2014, verification~~ Verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age nineteen (19) or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged ~~19-26~~ nineteen (19) to twenty-six (26), and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. Categorical relationship to ~~Refugee~~ refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer ~~(BCC) Treatment~~ treatment program is established in accordance with ~~OAC 317:35-21~~ Subchapter 21 of this Chapter. Categorical relationship for the SoonerPlan ~~Family Planning Program~~ family planning program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with ~~OAC 317:35-22~~ Subchapter 22 of the Chapter. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one (1) of the following eligibility groups and as defined above in this Section:

- (1) Aged;
- (2) Disabled;
- (3) Blind;
- (4) Pregnancy;
- (5) Children, including newborns deemed eligible;

- (6) ~~Caretaker Relatives~~ caretaker relatives;
 - (7) Refugee;
 - (8) ~~Breast and Cervical Cancer Treatment~~ BCC treatment program;
 - (9) ~~SoonerPlan Family Planning Program~~ family planning program;
 - (10) Benefits for pregnancies covered under Title XXI;
 - (11) Former foster care children; or
 - (12) Expansion adults.
- (b) The Authority may provide SoonerCare to reasonable categories of individuals under age twenty-one (21).
- (1) Individuals eligible for SoonerCare benefits include individuals between the ages of nineteen (19) and twenty-one (21):
 - (A) ~~for~~ For whom a public agency is assuming full or partial financial responsibility who are in custody as reported by ~~the Oklahoma Department of Human Services (OKDHS)~~ OKDHS and in foster homes, private institutions or public facilities; or
 - (B) ~~in~~ In adoptions subsidized in full or in part by a public agency; or
 - (C) ~~individuals~~ Individuals under age ~~twenty-one~~ twenty-one (21) receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age ~~twenty-one~~ twenty-one (21) are provided under the State Plan and the individuals are supported in full or in part by a public agency; or
 - (2) Individuals eligible for SoonerCare benefits include individuals between the ages of eighteen (18) and ~~twenty-one~~ twenty-one (21) if they are in custody as reported by OKDHS on their ~~18th~~ eighteenth (18th) birthday and living in an ~~out-of-home~~ out-of-home placement.

317:35-5-9. Determining the categorical relationship to expansion adults

- (a) To be eligible for SoonerCare under expansion adults, individuals shall meet the following requirements:
- (1) Are age nineteen (19) years or older, and under age sixty-five (65);
 - (2) Are not pregnant;
 - (3) Are not entitled to or enrolled for Medicare benefits under part A or B;
 - (4) Are not eligible for SoonerCare in another mandatory eligibility group under Oklahoma's Medicaid State Plan;
 - (5) Have household income that is at or below 133 percent of the federal poverty level (FPL) for their household size; and
 - (6) Meet general SoonerCare program eligibility requirements described in Oklahoma Administrative Code (OAC) 317:35, including but not limited to citizenship and residence requirements.
- (b) An individual whose household's modified adjusted gross income (MAGI) exceeds the income standard for participation under the parent and caretaker relative group, including those eligible for transitional medical assistance per 317:35-6-64.1, may participate in expansion adults if:
- (1) The individual resides with and assumes primary responsibility for the care of a child under nineteen (19) years of age; and
 - (2) The child is enrolled in SoonerCare or other minimum essential coverage, as described by the Affordable Care Act.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-48. Determination of income and resources for categorical relationship to expansion adults

Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to expansion adults. See Subchapter 6 of this Chapter for MAGI rules.

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-60. Application for SoonerCare; forms

(a) **Application.** An application for ~~Medical Services~~medical services consists of the ~~Medical Assistance Application~~SoonerCare application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare. ~~Effective January 1, 2014, the~~The application form is available as an online application, as a paper form, and is available to be completed by telephone with the assistance of the agency.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant, or have children or are applying for family planning services only. A ~~face-to-face~~face-to-face interview is not required. Only SoonerCare applications for women who are pregnant, and families with children and for family planning services are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or OKDHS form 08MA005E for individuals who are pregnant, or have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. ~~Effective October 1, 2013, an~~An application for SoonerCare may also be submitted through the Health Insurance Exchange.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification of a need for medical services. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and an application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within ~~20~~twenty (20) days by a signed application, the documented date of the oral request is the date of application. When

OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within ~~20~~twenty (20) days by a signed application for SoonerCare.

317:35-5-63. Agency responsible for determination of eligibility

(a) **Determination of eligibility by Oklahoma Health Care Authority (OHCA).** OHCA is responsible for determining eligibility for the following eligibility groups:

- (1) ~~children~~Children;
- (2) ~~newborns~~Newborns deemed eligible;
- (3) ~~pregnant~~Pregnant women;
- (4) ~~pregnancy-related~~Pregnancy-related services under Title XXI;
- (5) ~~parents~~Parents and caretaker relatives;
- (6) ~~former~~Former foster care children;
- (7) ~~Oklahoma Cares-Breast and Cervical Cancer program~~(BCC) treatment program;
- (8) SoonerPlan ~~Family Planning~~family planning program-;
- (9) Programs of All-Inclusive Care for the Elderly (PACE); and
- (10) Expansion adults.

(b) **Determination of eligibility by ~~DHS~~OKDHS.** ~~DHS~~OKDHS is responsible for determining eligibility for the following eligibility groups:

- (1) TANF recipients;
- (2) ~~recipients~~Recipients of adoption assistance or kinship guardianship assistance;
- (3) ~~state~~State custody;
- (4) Refugee ~~Medical Assistance~~medical assistance;
- (5) ~~aged~~Aged;
- (6) ~~blind~~Blind;
- (7) ~~disabled~~Disabled;
- (8) Tuberculosis;
- (9) ~~QMBP~~Qualified Medicare Beneficiary Plus (QMBP);
- (10) ~~QDWI~~Qualified Disabled Working Individual (QDWI);
- (11) ~~SLMB~~Specified Low-Income Medicare Beneficiary (SLMB);
- (12) ~~QI-1~~Qualifying Individual (QI-1);
- (13) ~~Long-term~~Long-term care services; and
- (14) ~~alien~~Alien emergency services.

(c) **Determination of eligibility for programs offered through the Health Insurance Exchange.** ~~Effective October 1, 2013,~~ OHCA assesses applicants who are found to be ineligible for SoonerCare for potential eligibility for affordable insurance programs offered through the Health Insurance Exchange. OHCA does not determine eligibility or ineligibility for those programs. OHCA facilitates the determination for those affordable insurance programs by forwarding applicants' electronic applications to the Health Insurance Exchange.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 1. GENERAL

317:35-6-1. Scope and applicability

(a) The rules in this Subchapter apply when determining financial eligibility for SoonerCare ~~Health~~

~~Benefits~~health benefits for groups whose eligibility is determined using Modified Adjusted Gross Income (MAGI). These rules apply to the following groups:

- (1) Children;
 - (2) Pregnant women;
 - (3) Pregnancy-related services under Title XXI;
 - (4) Parents and caretaker relatives;
 - (5) SoonerPlan ~~Family Planning~~family planning program;
 - (6)Independent foster care adolescents;
 - ~~(7) Inpatients in public psychiatric facilities under 21, and~~
 - (7) Individuals under age twenty-one (21) in public psychiatric facilities;
 - (8) Tuberculosis;
 - (9) Former foster care children;
 - (10) Children with non-IV-E adoption assistance;
 - (11) Individuals in adoptions subsidized in full or part by a public agency; and
 - (12) Expansion adults.
- (b) See ~~42 Code of Federal Regulation, Sec. 435.60342~~ C.F.R. § 435.603 to determine whether MAGI applies to a group not specifically listed in this Section.
- (c) MAGI rules ~~take~~took effect on October 1, 2013.

PART 3. APPLICATION PROCEDURES

317:35-6-15. Application for SoonerCare for Pregnant Women and Families with Children~~SoonerCare application for pregnant women, families with children, and expansion adults; forms~~

(a) **Application.** An application for pregnant women ~~and~~ families with children, and expansion adults consists of the SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare. ~~Effective October 1, 2013, individuals~~Individuals who wish to use a paper application form to apply for coverage under a MAGI eligibility group must submit the federal Single Streamlined Application to apply for SoonerCare.

- (1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, ~~Health Department, in the county OKDHS office~~Oklahoma Department of Health, in the individual's county Oklahoma Department of Human Services (OKDHS) office, or online. A ~~face-to-face~~face-to-face interview is not required. Applications are mailed to the OHCA Eligibility Unit. When an individual indicates a need for SoonerCare, the physician or facility may forward an application to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. ~~Effective October 1, 2013, an~~An application for SoonerCare may also be submitted through the Health Insurance Exchange.
- (2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification of a need for medical services. The form also may be accepted as medical verification of pregnancy.
- (3) Receipt of the SoonerCare Applicationapplication form or OKDHS form 08MA005E constitutes an application for SoonerCare.
- (4) If OKDHS form 08MA005E is received and a SoonerCare application cannot be

completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) A hospital providing services may file an electronic Notification of Date of Service (NODOS) form with OHCA up to five (5) days from the date services are rendered. The hospital, applicant, or someone acting on the applicant's behalf has fifteen (15) days from the date the NODOS form was received by OHCA to submit a completed SoonerCare application. Filing a ~~Notification of Date of Service~~NODOS does not guarantee coverage and if a completed application is not submitted within fifteen (15) days, the NODOS is void.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within ~~20~~twenty (20) days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within ~~20~~twenty (20) days by a signed application for SoonerCare.

(c) **Other application and signature requirements.** For additional rules regarding other application and eligibility determination procedures, see Part 7 of Subchapter 5 of this Chapter.

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-36. Financial eligibility of individuals categorically related to AFDC or pregnancy-related services aid to families with dependent children (AFDC), pregnancy-related services or expansion adults

(a) ~~Prior to October 1, 2013. In determining~~When determining financial eligibility for an individual related to AFDC ~~or pregnancy-related services or expansion adults~~, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include the:

- (1) ~~the individual~~Individual;
- (2) ~~the spouse~~Spouse of the individual;
- (3) ~~the biological~~Biological or adoptive parent(s) of the individual who is a minor dependent child. For ~~Health Benefits~~health benefits only, income of the stepparent of the minor dependent child is determined according to OAC 317:35-5-45;
- (4) ~~minor~~Minor dependent children of the individual if the children are being included in the case for ~~Health Benefits~~health benefits. If the individual is ~~19~~nineteen (19) years or older and not pregnant, at least one (1) minor dependent child must be living in the home and included in the case for the individual to be related to AFDC;
- (5) ~~blood~~Blood related siblings, of the individual who is a minor child, if they are included in the case for ~~Health Benefits~~health benefits; or
- (6) ~~a caretaker~~Caretaker relative and spouse (if any) and minor dependent children when the caretaker relative is to be included for coverage.

(b) ~~Prior to October 1, 2013. The family has the option to exclude minor dependent children or blood related siblings [OAC 317:35-6-36(a)(4) and (5)] and their income from the eligibility process. However, for the adult to be eligible, at least one minor child and his/her income must be~~

included in the case. The worker has the responsibility to inform the family of the most advantageous consideration in regard to coverage and income. The MAGI methodology is used to determine eligibility for MAGI eligibility groups. See OAC 317:35-6-39 through 317:35-6-54.

~~(e) Effective October 1, 2013.~~ The MAGI methodology is used to determine eligibility for MAGI eligibility groups. See OAC 317:35-6-39 through OAC 317:35-6-54.

~~(d)(c) Effective October 1, 2013.~~ Individuals who are determined to be part of a MAGI household cannot be excluded from the household; likewise, income of individuals determined to be part of a MAGI household cannot be excluded unless the exclusion is expressly required under MAGI rules.

~~(e) When determining financial eligibility for an individual related to the children, parent or caretaker relative, or pregnancy groups, consideration is not given to income of any person who is aged, blind or disabled and receives SSI or is determined to be categorically needy.~~

317:35-6-37. Financial eligibility of categorically needy individuals related to AFDC or pregnancy-related services said to families with dependent children (AFDC), pregnancy-related services, parent/caretaker relatives, families with children, and expansion adults

Individuals whose income is less than the ~~SoonerCare Income Guidelines~~ income guidelines for the applicable eligibility group are financially eligible for SoonerCare.

(1) **Categorically related to pregnancy-related services.** For an individual related to pregnancy-related services to be financially eligible, the countable income must be less than the appropriate standard according to the family size on the ~~SoonerCare Income Guidelines~~ income guidelines. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **Categorically related to ~~children's and parent/caretakers' groups~~ the children and parent/caretaker relative groups.**

(A) **Parent/caretakers' caretaker relative group.** For the individual in the ~~parent/caretakers' caretaker relative~~ group to be considered categorically needy, the ~~SoonerCare Income Guidelines~~ income guidelines must be used.

(i) ~~SoonerCare Income Guidelines.~~ Individuals age ~~19~~nineteen (19) years or older, other than pregnant women, are determined categorically needy if countable income is ~~lessequal to or less~~ than the ~~Categorically Needy Standard~~ categorically needy standard, according to the family size.

(ii) ~~SoonerCare Income Guidelines.~~ All individuals under ~~19~~nineteen (19) years of age are determined categorically needy if countable income is equal to or less than the ~~Categorically Needy Standard~~ categorically needy standard, according to the size of the family.

(B) **Families with children.** Individuals who meet financial eligibility criteria for the ~~children's~~ children and ~~parent/caretakers'~~ parent/caretaker relative groups are:

(i) All persons included in an active TANF case.

(ii) Individuals related to the ~~children's~~ children or ~~parent/caretakers'~~ parent/caretaker relative groups whose countable income is within the current appropriate income standard, but who do not receive TANF assistance.

(iii) All persons in a TANF case in ~~Work Supplementation~~ work supplementation status who meet TANF eligibility conditions other than earned income.

(iv) Those individuals who continue to be eligible for Medicaid in a TANF case after they become ineligible for a TANF payment. These individuals will continue to be considered categorically needy if the TANF case was closed due to child or spousal

support, the loss or reduction of earned income exemption by any member of the assistance unit, or the new or increased earnings of the parent/caretaker relative.

(3) **Expansion adults.** Individuals who meet financial eligibility criteria for expansion adults are established and defined by 42 C.F.R. § 435.119 and by the Oklahoma Medicaid State Plan.

SUBCHAPTER 7. MEDICAL SERVICES

PART 1. GENERAL

317:35-7-1. Scope and applicability

~~The rules in this Subchapter apply when determining eligibility for Medical Services under Medicaid.~~ The rules in this Subchapter apply when determining eligibility for medical services for children who are reported by OKDHS as being in custody and individuals categorically related to: Aged, Blind and Disabled (ABD); Tuberculosis; SoonerPlan family planning program; Qualified Medicare Beneficiary Plus (QMBP); Qualified Disabled Working Individual (QDWI); Specified Low-Income Medicare Beneficiary (SLMB); Qualifying Individual (QI-1); and TEFRA.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60. Certification for SoonerCare

~~(a) The rules in this Section apply to all categories of eligibles **EXCEPT:**~~

- ~~(1) categorically needy SoonerCare members who are categorically related to AFDC or Pregnancy Related Services, AND~~
- ~~(2) who if eligible, would be enrolled in SoonerCare, or~~
- ~~(3) individuals categorically related to the Family Planning Program.~~

~~(b) An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the first day of the third month prior to the month of application if all eligibility criteria are met during the three month period. The certification period is determined beginning with the month the medical service was received or expected to be received or the month of application for categorically needy cases in which a medical service has not been received. The period of certification may cover retroactive or future months.~~

~~(1) **Certification as categorically.** A categorically needy individual who is categorically related to ABD is assigned a certification period of 12 months. A categorically needy individual who is determined eligible for a State Supplemental Payment (SSP) is certified effective the month of application. If the individual is also eligible for payment for medical services received during the three months preceding the month of application, the SoonerCare benefit is certified for the appropriate months. If the individual is not eligible for SSP, the first month of certification is the month that a medical service was provided or, if no medical service was provided, the month of application.~~

~~(A) **Certification of individuals categorically needy and categorically related to ABD.** The certification period for the individual categorically related to ABD can be assigned for up to 12 months. The individual must be determined as categorically needy for each month of the certification period. The certification period is 12 months unless the individual:~~

- ~~(i) is certified as eligible in a money payment case during the 12 month period;~~
- ~~(ii) is certified for long term care during the 12 month period;~~

- (iii) becomes ineligible for medical assistance after the initial month;
- (iv) becomes ineligible as categorically needy; or
- (v) is deceased.

~~(B) Certification period.~~ If any of the situations listed in subparagraph (A) of this paragraph occur after the initial month, the case is closed by the worker.

~~(i) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.~~

~~(ii) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.~~

(a) General. The rules in this Section apply to the following categories of eligibles:

(1) Categorically needy SoonerCare members who are categorically related to Aged, Blind, and Disabled (ABD);

(2) Categorically needy SoonerCare members who are categorically related to ABD, and are eligible for one of the following:

(A) Qualified Medicare Beneficiary Plus (QMBP);

(B) Qualified Disabled and Working Individual (QDWI);

(C) Specified Low-Income Medicare Beneficiary (SLMB);

(D) Tuberculosis (TB) related services;

(E) Qualifying Individual (QI); or

(F) Tax Equity and Fiscal Responsibility Act (TEFRA).

(b) Certification of individuals categorically needy and categorically related to ABD. The certification period for the categorically needy individual who is categorically related to ABD can be up to twelve (12) months from the date of certification. The individual must meet all factors of eligibility for each month of the certification period. The certification can be for a retroactive period of coverage, during the three (3) months directly before the month of application, if the individual received covered medical services at any time during those three (3) months and would have been eligible for SoonerCare at the time he or she received the services. The cash payment portion of the State Supplemental Payment (SSP) may not be paid for any period prior to the month of application.

(1) The certification period is twelve (12) months unless the individual:

(A) Is certified as eligible in a money payment case during the twelve (12) month period;

(B) Is certified for long-term care during the twelve (12) month period;

(C) Becomes ineligible for medical assistance after the initial month;

(D) Becomes ineligible as categorically needy; or

(E) Is deceased.

(2) If any of the situations listed in subparagraph (1) of this paragraph occur after the initial month, the case is closed by the worker.

(A) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.

(B) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.

~~(2)(c)~~ **Certification of individuals categorically related to ABD and eligible as Qualified Medicare Beneficiaries Plus QMBP.** The SoonerCare benefit may be certified on the first day of the third month prior to the month of application or later. If the individual receives Medicare and is eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the month of certification for SSP. If the individual receives Medicare and is not eligible for SSP,

the effective date of certification for the Medicare Part B premium buy-in is the first day of the month following the month in which the eligibility determination is made (regardless of when application was made).

~~(A)~~(1) An individual determined eligible for QMBP benefits is assigned a certification period of ~~12~~twelve (12) months. At any time during the certification period that the individual becomes ineligible, the case is closed using regular negative action procedures.

~~(B)~~(2) At the end of the certification period a redetermination of QMBP eligibility is required, using the same forms and procedures as for ABD categorically needy individuals.

~~(3)~~(d) **Certification of individuals categorically related to ABD and eligible as Qualified Disabled and Working Individual QDWI.** The Social Security Administration (SSA) is responsible for referrals of individuals potentially eligible for QDWI. Eligibility factors verified by the SSA are Medicare Part A eligibility and discontinuation of disability benefits due to excessive earnings. When the OKDHS State ~~Office~~office receives referrals from the SSA, the county will be notified and is responsible for obtaining an application and establishing other factors of eligibility. If an individual contacts the county office stating he/she has been advised by SSA that he/she is a potential QDWI, the county takes a SoonerCare application. The effective date of certification for QDWI benefits is based on the date of application and the date all eligibility criteria, including enrollment for Medicare Part A, are met. For example, if an individual applies for benefits in October and is already enrolled in Medicare Part A, eligibility can be effective October 1 (~~for up to three (3) months prior to October 1, if all eligibility criteria are met during the three (3) month period~~). However, if in the example, the individual's enrollment for Part A is not effective until November 1, eligibility cannot be effective until that date. Eligibility can never be effective prior to July 1, 1990, the effective date of this provision. These cases will be certified for a period of ~~12~~twelve (12) months. At the end of the ~~12-month~~twelve (12) month period, eligibility redetermination is required. If the individual becomes ineligible at any time during the certification period, the case is closed.

~~(4)~~(e) **Certification of individuals categorically related to ABD and eligible as Specified Low-Income Medicare Beneficiary (SLMB) SLMB.** The effective date of certification of SLMB benefits may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for SLMB benefits is assigned a certification period of ~~12~~twelve (12) months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period a redetermination of SLMB eligibility is required. A redetermination of SLMB eligibility must also be done at the same time a dually eligible individual has a redetermination of eligibility for other SoonerCare benefits such as long-term care.

~~(5)~~(f) **Certification of individuals categorically related to disability and eligible for TB related services.**

~~(A)~~(1) An individual determined eligible for TB related services may be certified the first day of the third month prior to the month of application or later, but no earlier than the first day of the month the TB infection is diagnosed.

~~(B)~~(2) A certification period of ~~12~~twelve (12) months will be assigned. At any time during the certification period that the individual becomes ineligible, the case is closed using the regular negative action procedures.

~~(C)~~(3) At the end of the certification period a new application will be required if additional treatment is needed.

~~(6)~~(g) **Certification of individuals categorically related to ABD and eligible as Qualifying Individuals QI.** The effective date of certification for the QI-1 may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for QI benefits is assigned a certification period of ~~12~~twelve (12) months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of QI eligibility is required.

~~(A)~~(1) Since the State's allotment to pay Medicare premiums for this group of individuals is limited, the State must limit the number of QIs so that the amount of assistance provided during the year does not exceed the State's allotment for that year.

~~(B)~~(2) Persons selected to receive assistance are entitled to receive assistance with their Medicare premiums for the remainder of the federal fiscal year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year.

~~(7)~~(h) **Certification of individuals Relatedrelated to Aid to the Disabled for TEFRA.** The certification period for individuals categorically related to the Disabled for TEFRA is ~~12~~twelve (12) months.

SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

PART 3. RESOURCES

317:35-10-10. Capital resources

Capital resources are disregarded for individuals related to the children, parent and caretaker relative, former foster care children, SoonerPlan family planning program, expansion adults, or pregnancy eligibility groups, including pregnancies covered under Title XXI. Countable income generated from any resource is considered in accordance with Part 6 of Subchapter 6 of this Chapter.

PART 5. INCOME

317:35-10-26. Income

(a) General provisions regarding income.

(1) The income of categorically needy individuals who are related to the children, ~~parent or caretaker relative~~parent/caretaker relative, SoonerPlan family planning program, ~~or~~ Title XIX and XXI pregnancy eligibility groups or expansion adults does not require verification, unless questionable. If the income information is questionable, it must be verified. If there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or ~~OHCA's~~Oklahoma Health Care Authority's (OHCA's) policy, is taken into consideration in determining need. Income is considered available both when it is actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or

garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the ~~Oklahoma Health Care Authority (OHCA)~~ OHCA. The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within ten (10) days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to ~~an~~ SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. The ~~MAGI~~ Modified Adjusted Gross Income (MAGI) methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in ~~OAC~~ Oklahoma Administrative Code (OAC) 317:35-6-1.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. If OHCA is unable to verify income through the Oklahoma Employment Securities Commission, then pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer and provided to OHCA within ten (10) days. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received, with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain

retroactive SSI benefits for disabled/blind children under age eighteen (18) are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) Whether a source of income is countable for MAGI eligibility groups is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(B) Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy. Income received by a stepparent is considered in accordance with MAGI household and income counting rules.

(D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

(E) Recurring lump sum income received from any source for a period covering more than one (1) month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six (6) months, will be averaged and considered as income for the next six (6) months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six (6) months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company. Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two (2) months to establish the amount to be anticipated and considered for prospective budgeting.

(6) MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) MAGI household and income counting rules are used to determine whether a caretaker relative and his/her spouse or a stepparent are included in the household and whether their income is considered for the children.

(B) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted. If an individual is eligible in the parent or caretaker relative group, his/her spouse, if living with him/her, is also related to the parent or caretaker relative group.

(7) A stepparent, if living with the parent or caretaker relative, can also be related to the parent or caretaker relative group, regardless of whether the parent is incapacitated or not in the home.

(8) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged

as self-employed or as an employee. Whether income is countable for MAGI eligibility groups is determined using MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(1) **Earned income from self-employment.** For MAGI eligibility groups, the calculation of countable self-employment income is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(2) **Earned income from wages, salary or commission.** Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(3) **Earned income from work and training programs.** Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(4) **No individual earned income exemptions.** No earned income exemptions are subtracted to determine countable income for MAGI eligibility groups. The only deduction applied to determine net countable income under the MAGI methodology is the deduction of five percent (5%) of the ~~FPL~~Federal Poverty Level (FPL) for the individual's household size as defined in OAC 317:35-6-39.

(5) **Formula for determining the individual's net earned income for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

(c) **Unearned income.** Countable earned and unearned income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(d) **Income disregards.** For MAGI eligibility groups, whether a source of income is disregarded is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

~~(g)~~(e) **Computing monthly income.** In computing monthly income, cents will be rounded down at each step. Income which is received monthly but in irregular amounts is averaged using two (2) month's income, if possible, to determine income eligibility. Less than two (2) month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(2) **Weekly.** Income received weekly is multiplied by 4.3.

(3) **Twice a month.** Income received twice a month is multiplied by two (2).

(4) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA**

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-1. Purpose and general program provisions

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Insure Oklahoma program that establishes access to affordable health coverage for low-income working adults; their dependents, and their spouses; foster parents; and qualified college students.

317:45-1-2. Program limitations

(a) The Insure Oklahoma program is contingent upon federal waiver approval and sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) to implement the program.

(2) The program is funded through a portion of monthly proceeds from the Tobacco Tax, ~~Okla. Stat. '68 302-5~~Title 68 of the Oklahoma Statutes (O.S.) § 302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to ~~Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes~~68 O.S. §§ 302-5 (B)(1) & (C)(1) and 402-3 (B)(1) & (D)(1).

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma program continues to operate within its fiscal capacity.

(A) Insure Oklahoma may limit eligibility based on:

(i) ~~the federally approved Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver~~The 1115 Waiver;

(ii) Tobacco ~~Tax~~tax collections; and

(iii) ~~the~~The State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma program ~~are~~may be placed on a waiting list. Applications, with the exception of college students, are identified by region ~~and Insure Oklahoma program~~. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma program size is determined by OHCA and may be periodically adjusted.

- (ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.
- (iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.
- (iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.
- (v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate.
- (vi) For approved employers, if the employer has an employee who has a qualifying event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the qualifying event.

(b) College student eligibility and participation in the Insure Oklahoma program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) ~~an~~An insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) ~~a~~A Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) ~~a~~A domestic MEWA exempt from licensing pursuant to Title 36 ~~O.S., Section of the~~ Oklahoma Statutes (O.S.) § 634(B) that otherwise meets or exceeds all ~~of~~ the licensing and financial requirements of MEWAs as set out in ~~Article 6A of Title 36~~Title 36 O.S.; or

(D) ~~any~~Any entity organized pursuant to the Interlocal Cooperation Act, ~~Section 1001 et seq. of Title 74 of the Oklahoma Statutes~~74 O.S. § 1001 et seq. as authorized by ~~Title 36 Section 607.1 of the Oklahoma Statutes~~36 O.S. § 607.1 and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"~~Child Care Center~~care center" means a facility licensed by the Oklahoma Department of Human Services (DHS) which provides care and supervision of children and meets all the requirements in ~~OAC 340:110-3-1 through OAC 340:110-3-33~~340:110-3-275 through 340:110-3-311.

"~~College Student~~student" means an Oklahoma resident between the age of nineteen (19) through twenty-two (22) that is a full-time student at an Oklahoma accredited ~~University~~university or ~~College~~college.

~~"DHS" means the Oklahoma Department of Human Services.~~

"**Dependent**" means the spouse of the approved applicant and/or child under nineteen (19) years of age or his or her child nineteen (19) years through twenty-two (22) years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"**Eligibility period**" means the period of eligibility extending from an approval date to an end date.

"**Employee**" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"**Employer**" means the business entity that pays earned income to employees.

"**Employer Sponsored Insurance (ESI)**" means the program that provides premium assistance to qualified businesses for approved applicants.

"**Explanation of Benefit (EOB)**" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma member.

"**Full-time Employer~~employer~~**" means the employer who employs an employee per Federal and State regulations, to perform work in exchange for wages or salary.

"**Full-time Employment~~employment~~**" means a normal work week per Federal and State regulations.

~~"**Individual Plan (IP)**" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma ESI.~~

"**In-network**" means providers or health care facilities that are part of a benefit plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"**Insure Oklahoma (IO)**" means a benefit plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of benefit plan coverage for eligible populations.

"**Member**" means an individual enrolled in the Insure Oklahoma ESI ~~or IP~~ program.

"**Modified Adjusted Gross Income (MAGI)**" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

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

"**OESC**" means the Oklahoma Employment Security Commission.

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

"**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).

"**Premium**" means a monthly payment to a carrier for benefit plan coverage.

"**Primary Care Provider~~care provider~~ (PCP)**" means a provider under contract with the OHCA to provide primary care services, including all medically necessary referrals.

~~"**Professional Employer Organization~~employer organization~~ (PEO)**" means any person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et. seq. 40 O.S. § 600.1 et. seq.~~

"**Qualified Benefit Plan~~benefit plan~~ (QBP)**" means a benefit plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

"**Qualifying Event~~event~~**" means the occurrence of an event that permits individuals to join a group benefit plan outside of the "open enrollment period" and/or that allows individuals to

modify the coverage they have had in effect. Qualifying events are defined by the employer's benefit plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the OHCA.

317:45-1-4. Reimbursement for out-of-pocket expenses

(a) Out-of-pocket expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to five (5) percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket expenses in excess of the five (5) percent annual gross household income. An expense must be for an allowed and covered service by a ~~qualified benefit plan (QBP)~~ QBP to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a QBP's benefit summary and policies. For instance, if a QBP has multiple in-network reimbursement percentage methodologies (~~80%~~ eighty (80) percent for level 1 provider and ~~70%~~ seventy (70) percent for level 2 provider) the OHCA will only reimburse expenses related to the highest percentage network.

(b) For all eligible expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket expense. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket expenses.

SUBCHAPTER 7. INSURE OKLAHOMA ESI EMPLOYER ELIGIBILITY

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current benefit plan invoice. Due to timely filing requirements, subsidy payments will not be paid on invoices older than six (6) months.

SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

(b) The eligibility determination will be processed within thirty (30) days from the date the application is received. The employee will be notified in writing of the eligibility decision.

(c) All eligible employees described in this section must be enrolled in their employer's qualified benefit plan. Eligible employees must:

(1) ~~have~~ Have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma ESI Income Guidelines form;

(A) ~~Effective January 1, 2016, financial~~ Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~ 317:35-6-55 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma ESI Benefits.

- (2) ~~be~~Be a US citizen or alien as described in OAC 317:35-5-25;
 - (3) ~~be~~Be Oklahoma residents;
 - (4) ~~furnish~~Furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma ESI benefits;
 - (5) ~~not~~Not be receiving benefits from SoonerCare or Medicare;
 - (6) ~~be~~Be employed with a qualified employer at a business location in Oklahoma;
 - (7) ~~be~~Be age nineteen (19) through age sixty-four (64);
 - (8) ~~be~~Be eligible for enrollment in the employer's ~~qualified benefit plan~~QBP;
 - (9) ~~not~~Not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2);
 - (10) ~~select~~Select one of the ~~qualified benefit plans~~QBPs the employer is offering; and
 - (11) ~~provide~~Provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.
- (d) An employee's dependents are eligible when:
- (1) ~~the~~The employer's benefit plan includes coverage for dependents;
 - (2) ~~the~~The employee is eligible;
 - (3) ~~if~~If employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1 (a) (1)-(2); and
 - (4) ~~the~~The dependents are enrolled in the same benefit plan as the employee.
- (e) If an employee or their dependents are eligible for multiple ~~qualified benefit plans~~QBPs, each may receive a subsidy under only one benefit plan.
- (f) College students may enroll in the Insure Oklahoma ESI program as dependents. ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA) or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.
- (g) Working dependent children must have countable income at the appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.
- (h) ESI approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within ten (10) days of the change.
- (i) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

SUBCHAPTER 11. INSURE OKLAHOMA IP [REVOKED]

PART 1. INDIVIDUAL PLAN PROVIDERS [REVOKED]

317:45-11-1. Insure Oklahoma Individual Plan providers [REVOKED]

~~Insure Oklahoma Individual Plan (IP) providers must comply with existing SoonerCare rules found at 317:25 and 317:30. In order to receive reimbursement, the IP provider:~~

- ~~(1) must enter into a SoonerCare contract; and~~
- ~~(2) must complete Insure Oklahoma IP addendum if provider wants to provide primary care services as a PCP.~~

317:45-11-2. Insure Oklahoma Individual Plan (IP) provider payments [REVOKED]

~~Payment for covered benefits rendered to Insure Oklahoma IP members is made to contracted Insure Oklahoma IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in Oklahoma Administrative Code 317:30-3-1(f).~~

- ~~(1) Coverage of certain services requires prior authorization and may be based on a determination made by a medical consultant in individual circumstances; and~~
- ~~(2) The provider may collect the member's co-payment in addition to the SoonerCare reimbursement for services provided.~~

PART 3. INSURE OKLAHOMA IP MEMBER BENEFITS [REVOKED]

317:45-11-10. Insure Oklahoma IP adult benefit [REVOKED]

~~(a) All IP adult benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section is subject to specific non-covered services listed in OAC 317:45-11-11.~~

~~(b) A PCP referral is required to see any other provider with the exception of the following services:~~

- ~~(1) behavioral health services;~~
- ~~(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;~~
- ~~(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;~~
- ~~(4) women's routine and preventive health care services;~~
- ~~(5) emergency medical condition as defined in OAC 317:30-3-1; and~~
- ~~(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.~~

~~(c) IP covered adult benefits for in-network services and limits are listed in this subsection. Member cost sharing related to premium and co-payments cannot exceed federal maximums with the exception of emergency room visits, in which case the State establishes the maximum for member cost share. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage for IP services includes:~~

- ~~(1) Anesthesia/Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).~~
- ~~(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.~~
- ~~(3) Chelation Therapy. Covered for heavy metal poisoning only.~~
- ~~(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required.~~
- ~~(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a \$30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.~~
- ~~(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, OAC 317:30-5-47 and OAC 317:30-5-95.~~
- ~~(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year. This visit counts as an office visit.~~
- ~~(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, OAC 317:30-5-10, and OAC 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits.~~
- ~~(9) Outpatient Hospital/Facility Services.
 - ~~(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures.~~
 - ~~(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections.~~
 - ~~(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year. Must be hospital based.~~~~
- ~~(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22.~~
- ~~(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20.~~
- ~~(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901.~~
- ~~(13) Immunizations. Covered in accordance with OAC 317:30-5-2.~~
- ~~(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.~~
- ~~(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility.~~
- ~~(16) Oral Surgery. Services are limited to the removal of tumors or cysts.~~
- ~~(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1.~~
- ~~(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). Outpatient benefits are limited to 48 visits per calendar year. Additional visits may be approved as medically necessary.
 - ~~(A) Agency services. Covered in accordance with OAC 317:30-5-241 and OAC 317:30-5-596.~~
 - ~~(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services and Outpatient Substance Abuse Treatment:~~~~

- (i) ~~Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.~~
- (ii) ~~Practitioners with a license to practice in the state in which services are provided.
 - (I) ~~Psychology,~~
 - (II) ~~Social Work (clinical specialty only),~~
 - (III) ~~Professional Counselor,~~
 - (IV) ~~Marriage and Family Therapist,~~
 - (V) ~~Behavioral Practitioner, or~~
 - (VI) ~~Alcohol and Drug Counselor.~~~~
- (iii) ~~Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.~~
- (iv) ~~A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.~~
- (v) ~~LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.~~
- (vi) ~~LBHP services require prior authorization and are limited to four (4) therapy services per month per member and eight (8) testing units per year per member.~~
- (19) ~~Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5-210 through OAC 317:30-5-218. A PCP referral and prior authorization is required for certain items.~~
- (20) ~~Diabetic Supplies. Covered in accordance with OAC 317:30-5-211.15.~~
- (21) ~~Oxygen. Covered in accordance with OAC 317:30-5-211.11 through OAC 317:30-5-211.12.~~
- (22) ~~Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and OAC 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits.~~
- (23) ~~Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with OAC 317:30-5-72.1.~~
- (24) ~~Nutrition Services. Covered in accordance with OAC 317:30-5-1076.~~
- (25) ~~External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5-211.13.~~
- (26) ~~Surgery. Covered in accordance with OAC 317:30-5-8.~~
- (27) ~~Home Dialysis. Covered in accordance with OAC 317:30-5-211.13.~~
- (28) ~~Parenteral Therapy. Covered in accordance with OAC 317:30-5-211.14.~~
- (29) ~~Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57.~~
- (30) ~~Home Health and Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211.15 and OAC 317:30-5-42.16(b)(3).~~
- (31) ~~Fundus photography.~~
- (32) ~~Emergency ground ambulance transportation. Covered in accordance with OAC 317:30-5-336.~~

317:45-11-11. Insure Oklahoma IP adult non-covered services [REVOKED]

Certain health care services are not covered in the Insure Oklahoma IP adult benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

- (1) services not considered medically necessary;
- (2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
- (3) organ and tissue transplant services;
- (4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
- (5) procedures, services and supplies related to sex transformation;
- (6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
- (8) over the counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (9) experimental procedures, drugs or treatments;
- (10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident);
- (11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
- (12) physical medicine including chiropractic and acupuncture therapy;
- (13) hearing services;
- (14) non-emergency transportation and emergency air transportation;
- (15) allergy testing and treatment;
- (16) hospice regardless of location;
- (17) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (18) genetic counseling;
- (19) fertility evaluation/treatment/and services;
- (20) sterilization reversal;
- (21) Christian Science Nurse;
- (22) Christian Science Practitioner;
- (23) skilled nursing facility;
- (24) long term care;
- (25) stand by services;
- (26) thermograms;
- (27) abortions (for exceptions, refer to OAC 317:30-5-6);
- (28) services of a Lactation Consultant;
- (29) services of a Maternal and Infant Health Licensed Clinical Social Worker;
- (30) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1;
- (31) ultraviolet treatment-actinotherapy;
- (32) private duty nursing;
- (33) payment for removal of benign skin lesions;
- (34) sleep studies;
- (35) prosthetic devices; and
- (36) continuous positive airway pressure devices (CPAP).

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY [REVOKED]

317:45-11-20. Insure Oklahoma IP eligibility requirements [REVOKED]

- ~~(a) Oklahoma employed working adults not eligible to participate in an employer's qualified benefit plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. Applicants, unless a qualified college student, must be: considered "employed" in accordance with State law, including, but not limited to, Title 40 O.S. '1-210; engaged in routine, for profit activity, if self-employed; or considered "unemployed" in accordance with State law, including, but not limited to Title 40 O.S. '1-217. Applicants cannot obtain IP coverage if they are eligible for ESI.~~
- ~~(b) The eligibility determination will be processed within thirty (30) days from the date the complete application is received. The applicant will be notified of the eligibility decision.~~
- ~~(c) In order to be eligible for the IP, the applicant must:~~
- ~~(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time he/she completes application;~~
 - ~~(2) be a US citizen or alien as described in OAC 317:35-5-25;~~
 - ~~(3) be an Oklahoma resident;~~
 - ~~(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma IP benefits;~~
 - ~~(5) be not currently enrolled in, or have an open application for SoonerCare or Medicare;~~
 - ~~(6) be age 19 through 64;~~
 - ~~(7) make premium payments by the due date on the invoice;~~
 - ~~(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2);~~
 - ~~(9) be not currently covered by a private insurance policy or plan; and~~
 - ~~(10) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.~~
- ~~(d) If employed and working for an approved Insure Oklahoma employer who offers a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and:~~
- ~~(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.
 - ~~(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants do not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~
 - ~~(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits;~~~~
 - ~~(2) be ineligible for participation in their employer's qualified benefit plan due to number of hours worked.~~
- ~~(e) If employed and working for an employer who does not offer a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.
 - ~~(1) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable~~~~

MAGI rules for determining household composition and countable income.

(2) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(2) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2).

(3) must verify self-employment by completing and submitting to Insure Oklahoma the Self-Employment Attestation Form. In addition,

(A) for any applicant who filed a Federal tax return for the tax year immediately preceding the date of application, he or she must provide a copy of such tax return with all supporting schedules and forms, or

(B) for any applicant exempt from filing a Federal tax return for the previous tax year in accordance with Federal law, including, but not limited to, 26 Code of Federal Regulation, Section 1.6017-1, he or she must submit a completed 12-Month Profit and Loss Worksheet to Insure Oklahoma, as well as any other information requested by Insure Oklahoma that could reasonably be used to substantiate the applicant's regular, for-profit business activity.

(g) If unemployed seeking work, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(3) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits. Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) A OESC eligibility letter;

(B) A OESC weekly unemployment payment statement, or;

(C) A bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Applicants may need to verify eligibility of their enrollment in the Ticket to Work

program.

~~(3) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(4) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.~~

~~(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.~~

~~(j) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.~~

~~(k) College students may enroll in the Insure Oklahoma IP program as dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA) or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.~~

~~(l) Any misleading or false representation, or omission of any material fact or information required or requested by OHCA as part of the Insure Oklahoma application process, may result in, among other things, closure of eligibility pursuant to OAC 317:45-11-27.~~

317:45-11-21. Dependent eligibility [REVOKED]

~~(a) If the spouse of an Insure Oklahoma IP approved individual is eligible for Insure Oklahoma ESI, they must apply for Insure Oklahoma ESI. Spouses cannot obtain Insure Oklahoma IP coverage if they are eligible for Insure Oklahoma ESI.~~

~~(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in 317:45-11-20 (a) through (g) to be eligible for Insure Oklahoma IP.~~

~~(c) The dependent of an applicant approved according to the guidelines listed in 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma IP.~~

~~(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma IP, then the associated dependent enrolled under that applicant is also ineligible.~~

~~(e) College students may enroll in the Insure Oklahoma IP program. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students' are determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(f) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.~~

~~(g) When the agency responsible for determining eligibility for the member becomes aware of a change in the dependents circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.~~

317:45-11-21.1. Certification of newborn child deemed eligible [REVOKED]

~~(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma Individual Plan (IP) and the annual gross household income does not exceed SoonerCare requirements. The newborn child is deemed eligible for SoonerCare benefits through the last day of the month the child attains the age of one (1) year.~~

~~(b) The newborn child's SoonerCare eligibility is not dependent on the mother's continued eligibility in Insure Oklahoma IP. The child's SoonerCare eligibility is based on the original eligibility determination of the mother for Insure Oklahoma IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.~~

~~(c) The newborn child's certification period for SoonerCare is shortened only in the event the child:~~

~~(1) Loses Oklahoma residence; or~~

~~(2) Expires.~~

~~(d) No other conditions of eligibility are applicable, including social security number enumeration and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.~~

317:45-11-22. Primary Care Physician (PCP) choices [REVOKED]

~~(a) The applicant and any covered dependent(s) are required to select a valid PCP.~~

~~(b) The applicant and any covered dependent(s) must make a PCP selection through their mysoonerCare.org account.~~

~~(c) After initial enrollment in Insure Oklahoma Individual Plan the applicant any covered dependent(s) may change their PCP selection through their mysoonerCare.org account or by calling the Insure Oklahoma helpline.~~

~~(d) To ensure members have access to their Patient Centered Medical Home, Insure Oklahoma staff may facilitate enrollment as applicable.~~

317:45-11-23. Member eligibility period [REVOKED]

~~(a) The rules in this subsection apply to member's eligibility according to OAC 317:45-11-20(a) through (e).~~

~~(1) The member's eligibility period begins only after approval of the application and receipt of the premium payment.~~

~~(A) If the application is approved and the premium payment is made by the last day of the same month, eligibility will begin the first day of the next month.~~

~~(B) If the application is approved and the premium payment is made between the first and 15th day of the next month, eligibility will begin the first day of the second consecutive month.~~

~~(C) If the application is approved and the premium payment is not made within 45 days, eligibility will not begin.~~

~~(2) Employee eligibility is contingent upon the employer meeting the program guidelines.~~

~~(3) The employee's eligibility is determined using the eligibility requirements listed in OAC 317:45-9-1 or OAC 317:45-11-20 (a) through (e).~~

~~(4) If the employee is determined eligible for Insure Oklahoma IP, he/she is approved for a~~

period not greater than 12 months.

~~(b) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (e) and OAC 317:45-11-20(f) through (h).~~

~~(1) The applicant's eligibility is determined using the eligibility requirements listed in OAC 317:45-11-20(a) through (e) and OAC 317:45-11-20(f) through (h).~~

~~(2) If the applicant is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than twelve (12) months.~~

~~(3) The applicant's eligibility period begins only after receipt of the premium payment.~~

317:45-11-24. Member cost sharing [REVOKED]

~~(a) Members are given monthly invoices for their benefit plan premiums. IP health plan premiums are established by the OHCA. The premiums are due monthly and must be paid in full.~~

~~(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent (4%) of their monthly gross household income.~~

~~(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent (4%) of their monthly gross household income, based on a family size of one and capped at one hundred percent (100%) of the Federal Poverty Level.~~

~~(3) Cost sharing, including premium payments and copayments, are not required of American Indian and Alaska Native members, as is established in the federally approved Oklahoma Medicaid State Plan.~~

~~(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of returned payments.~~

317:45-11-26. Reviews [REVOKED]

~~Members participating in the Insure Oklahoma program are subject to reviews related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.~~

317:45-11-27. Closure [REVOKED]

~~(a) Members are mailed a notice 10 days prior to closure of eligibility.~~

~~(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma then eligibility for the associated employees enrolled under that employer are also ineligible.~~

~~(c) The employee's certification period may be terminated when:~~

~~(1) the member requests closure;~~

~~(2) the member moves out of state;~~

~~(3) the covered member dies;~~

~~(4) the employer's eligibility ends;~~

~~(5) a review indicates a discrepancy that makes the member or employer ineligible;~~

~~(6) the employer is terminated from Insure Oklahoma;~~

~~(7) the member fails to pay their premium;~~

~~(8) the qualified benefit plan or carrier no longer meets the requirements set forth in this chapter;~~

~~(9) the member begins receiving SoonerCare or Medicare benefits;~~

- ~~(10) the member begins receiving coverage by a private benefit policy or plan;~~
 - ~~(11) the member or employer reports any change affecting eligibility; or~~
 - ~~(12) the member no longer meets the eligibility criteria set forth in this Chapter.~~
- ~~(d) This subsection applies to applicants eligible according to 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:~~
- ~~(1) the member requests closure;~~
 - ~~(2) the member moves out of state;~~
 - ~~(3) the covered member dies;~~
 - ~~(4) the employer's eligibility ends;~~
 - ~~(5) a review indicates a discrepancy that makes the member or employer ineligible;~~
 - ~~(6) the member fails to pay their premium;~~
 - ~~(7) the member becomes eligible for SoonerCare or Medicare;~~
 - ~~(8) the member begins receiving coverage by a private benefit policy or plan;~~
 - ~~(9) the member or employer reports any change affecting eligibility; or~~
 - ~~(10) the member no longer meets the eligibility criteria set forth in this Chapter.~~

317:45-11-28. Appeals [REVOKED]

~~Member appeal procedures based on denial of eligibility due to income are described at 317:2-1-2.~~

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.6. Trust accounts

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, or the Bureau of Indian Affairs-(BIA).

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the Oklahoma Department of Human Services (OKDHS) State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms.** The following words and terms, when used in this paragraph, have the following meaning, unless the context clearly indicates otherwise:

(A) **Beneficiary.** Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal.** Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers.** Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions.** Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

(F) **Irrevocable trust.** Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust.** Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary.** Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust.** Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary.** Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust.** Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee.** Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) Medicaid Qualifying Trust (MQT). A MQT is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to 12 Oklahoma Statutes 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device.** MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment.** For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources.** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g.,

if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(i) the individual;

(ii) the individual's spouse;

(iii) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(iv) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the ~~60~~sixty (60) months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the ~~60~~sixty (60) months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

- (6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:
- (A) A trust containing the assets of a disabled individual under the age of ~~65~~sixty-five (65) which was established for the benefit of such individual by the individual, parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:
- (i) The trust may only contain the assets of the disabled individual.
 - (ii) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OKDHS or the Oklahoma Health Care Authority (OHCA).
 - (iii) Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.
 - (iv) The exception for the trust continues after the disabled individual reaches age ~~65~~sixty-five (65). However, any addition or augmentation after age ~~65~~sixty-five (65) involves assets that were not the assets of an individual under age ~~65~~sixty-five (65); therefore, those assets are not subject to the exemption.
 - (v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of ~~65~~sixty-five (65).
 - (vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, ~~clothing~~ and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, ~~clothing~~, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, ~~clothing~~, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.
 - (vii) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.
 - (viii) The OKDHS Form 08MA018E, Supplemental Needs Trust, is an example of the trust. Workers may give the sample form to the member or his/her representative to use or for their attorney's use.
 - (ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services (~~HR&MS~~), explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services (HRMS) notifies Oklahoma Health Care Authority/Third Party Liability (OHCA/TPL) to initiate the recovery process.
- (B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:
- (i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1 Schedule

VIII.B) but less than the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).

(ii) The ~~Trust~~ trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.

(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.

(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administering the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to ~~3%~~ three percent (3%) of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason and effective date for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. ~~Health Related and Medical Services~~ HRMS notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the OKDHS and may not be amended without the permission of the OKDHS;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

- (vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;
- (vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;
- (viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of ~~30%~~thirty percent (30%) of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs (~~BIA~~)**. Interests of individual Indians in trust or restricted lands are not considered in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust**. At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-35. Oklahoma State Health Information Network and Exchange (OKSHINE)

(a) Authority. This rule is promulgated under the authority granted in Title 63 of the Oklahoma Statutes Section 1-133 (63 O.S. § 1-133). This Section is intended to be read in conjunction with applicable Oklahoma statutes and federal law.

(b) Applicability and purpose.

(1) Applicability. This section shall apply to and govern the establishment and operation of the statewide health information exchange (HIE), herein referred to as OKSHINE.

(2) Purpose. OKSHINE is the state-designated organization that facilitates the exchange of health information to and from authorized individuals and health care organizations in the state for the purpose of improving health outcomes, as per 63 O.S. § 1-133.

(c) Definitions. The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) OKSHINE means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care organizations as defined in the Oklahoma Statutes, to improve the security of patient information, coordination of patient care, and the efficiency of health care delivery.

(2) Participant means an organization, health care practitioner or institution, health plan, or health care clearinghouse who has executed a written participation agreement (PA) and business associate agreement (BAA) with OKSHINE.

(3) Participant agreement means the agreement between OKSHINE and a participant which authorizes the participant to have access to OKSHINE and outlines the policies and procedures for access, protection, and use of the electronic protected health information.

(4) Oklahoma Statewide Health Information Exchange (OKHIE) means a certified HIE as referenced in 63 O.S. § 1-133 whose primary business activity is health information exchange.

(d) OKHIE Certification. Per 63 O.S. § 1-133, an initial certification and an annual recertification will be required for health information exchanges to qualify as an OKHIE. In order to receive certification, the applying HIE must submit an application to the Oklahoma Health Care Authority (OHCA) and provide all requested documentation. The application and standards for certification shall be posted on the OHCA OKSHINE public website.

(1) The OHCA shall establish a health information exchange certification with input from stakeholders.

(2) Until such time as the health information exchange certification is established by the OHCA, an OKSHINE or an HIE organization that was previously certified by the Oklahoma Health Information Exchange Trust (OHIET) shall be deemed an OKHIE.

(3) An HIE must provide documentation of certification from OHIET to OHCA in order to receive initial OKHIE certification.

(e) Fees.

(1) **Certification fees.** Each health information exchange which applies for certification, will be required to pay annual certification/recertification fees. The OHCA will develop the certification criteria and will publish the criteria and associated fees, when available, on the OHCA OKSHINE public website.

(2) **Participant fees.** Each participant, as defined in this section, will be required to pay an annual participation fee as outlined in the participant agreement. The OHCA will develop the criteria for the fees and will publish the criteria when available. The participant agreement and fee schedule will be posted on the OHCA OKSHINE public website.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-58. Supplemental Hospital Offset Payment Program

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes (O.S.).

(b) **Definitions.** The following words and terms, when used in this Section have the following meaning, unless the context clearly indicates otherwise:

(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care Authority (OHCA) if the hospital's data is not included in a Medicare Cost Report.

(2) **"Directed payments"** means payment arrangements allowed under 42 Code of Federal Regulations (C.F.R.) Section (§) 438.6(c) that permit states to direct specific payments made by managed care plans to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs.

~~(2)(3)~~ **"Fee"** means supplemental hospital offset assessment pursuant to Section (§) 3241.1 of Title 63 of the ~~Oklahoma Statutes~~O.S.

~~(3)(4)~~ **"Hospital"** means an institution licensed by the State Department of Health as a hospital pursuant to ~~Section §~~ 1-701.1 of Title 63 of the ~~Oklahoma Statutes~~O.S. maintained primarily for the diagnosis, treatment, or care of patients.

~~(4)(5)~~ **"Hospital Advisory Committee"** means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.

~~(5)(6)~~ **"NET hospital patient revenue"** means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines "Total inpatient routine care services", "Ancillary services", "Outpatient services") of the Medicare ~~Cost Report~~cost report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)"Net patient revenues") and Worksheet G-2 (Part I, Column 3, Line "Total patient revenues").

~~(6)(7)~~ **"Medicare ~~Cost Report~~cost report"** means the ~~Hospital Cost Report~~hospital cost report, Form CMS-2552-96 or subsequent versions.

~~(7)(8)~~ **"Upper payment limit"(UPL)** means the maximum ceiling imposed by ~~42 C.F.R.~~ 42 C.F.R. §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and outpatient services, other than to hospitals owned or operated by state government.

~~(8)(9)~~ **"Upper payment limit gap"** means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to ~~63 Okla. Stat. O.S. §§ 3241.1 through 3241.6~~ the ~~Oklahoma Health Care Authority (OHCA)~~OHCA is mandated to assess hospitals licensed in Oklahoma, unless exempted under (c) (2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

(A) ~~a~~A hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicare and Medicaid Services and State operations.

(B) ~~a~~A hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C) ~~a~~A hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, using the Inpatient Discharge Data File published by the Oklahoma State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, using substantially equivalent data provided by the hospital:

(i) ~~treatment~~Treatment of a neurological injury;

(ii) ~~treatment~~Treatment of cancer;

(iii) ~~treatment~~Treatment of cardiovascular disease;

(iv) ~~obstetrical~~Obstetrical or childbirth services; or

(v) ~~surgical~~Surgical care except that this exemption will not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery.

(D) ~~a~~A hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital, according to the most recent list of LTCH's published on the CMS <http://www.cms.gov/LongTermCareHospitalPPS/08download.asp> or as a children's hospital; and

(E) ~~a~~A hospital that is certified by CMS as a critical access hospital, according to the most recent list published by Flex Monitoring Team for Critical Access Hospital (CAH) Information at <http://www.flexmonitoring.org/cahlistRA.cgi>, which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) ~~The Supplemental Hospital Offset Payment Program~~SHOPP Assessment.

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. ~~The assessment rate until December 31, 2012, is two and one half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%).~~The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, in an amount calculated as a percentage of each hospital's net hospital patient revenue. At no time will the assessment rate exceed four percent (4%). For the calendar year ending December 31, 2022, the assessment rate shall be fixed at three percent (3%). For the calendar year ending December 31, 2023, the assessment rate shall be fixed at three and one-half percent (3.5%). For the calendar year ending December 31, 2024 and for all subsequent calendar years shall, the assessment rate exceed shall be fixed at four percent (4%).

~~(2) OHCA will review and determine the amount of annual assessment in December of each year.~~

~~(3)~~(2) A hospital may not charge any patient for any portion of the SHOPP assessment.

(4)(3) The ~~Method~~method of collection is as follows:

(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.

(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the hospital's net patient revenue calculation, and the assessment amount.

(C) New hospitals will only be added at the beginning of each calendar year.

(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)

(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th ~~will~~may result in a debt to the State of Oklahoma and is subject to penalties of ~~5%~~five percent (5%) of the amount ~~and interest of 1.25% one and a quarter percent (1.25%) per month.~~

(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA ~~will~~may add to the assessment:

(i) ~~a~~A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

(ii) ~~on~~On the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(iii) ~~the~~The quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the invoice to the provider, the assessment, and applicable penalty, ~~and interest~~ will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in future payments in accordance with ~~OAC~~Oklahoma Administrative Code (OAC) 317:2-1-15 SHOPP appeals.

(iv) If additional allocation or recoupment resulting from an appeal is for the current calendar year and another SHOPP payment is scheduled for the calendar year, an adjustment to the next payment will be calculated. If additional allocation or recoupment is for a prior calendar year, a separate payment/account receivable (AR) will be issued.

(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.

(e) ~~Supplemental Hospital Offset Payment Program~~SHOPP Cost Reports.

(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at ~~42 U.S.C.~~United States Code (U.S.C.) Section 1320a-7b which states, in part,

"Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefits or payment...shall (i) in the case of such statement, representation, failure, or conversion by any person in connection with furnishing (by the person) of items or services for which payment is or may be under this title (42 U.S.C. § 1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than ~~\$25,000~~twenty-five thousand dollars (\$25,000) or imprisoned for not more than five (5) years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than ~~\$10,000~~ten thousand dollars (\$10,000) or imprisoned for not more than one year, or both."

(4) Net hospital patient revenue is determined using the data from each hospital's applicable Medicare ~~Cost Report~~cost report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System (HCRIS) file. The base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g. calendar year 2022 will use 2020 fiscal year cost reports), as contained in the HCRIS file dated June 30 of each year.

~~(A) Through 2013, the base year for assessment shall be the hospital's fiscal year that ended in 2009, as contained in the HCRIS file dated December 31, 2010;~~

~~(B) For years 2014 and 2015, the base year for assessment shall be the hospital's fiscal year that ended in 2012, as contained in the HCRIS file dated June 30, 2013; and~~

~~(C) For subsequent two-year periods the base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g., 2016 & 2017 B 2014 fiscal year; 2018 & 2019 B 2016 fiscal year), as contained in the HCRIS file dated June 30 of the following year.~~

(5) If a hospital's applicable Medicare ~~Cost Report~~cost report is not contained in the Centers for Medicare and Medicaid Services' HCRIS file, the hospital will submit a copy of the hospital's applicable Medicare ~~Cost Report~~cost report to the ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a Medicare ~~Cost Report~~cost report, the hospital will submit its initial Medicare ~~Cost Report~~cost report to ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis. Hospitals whose assessments were based on partial year cost reports will be reassessed the following year using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) Closure, merger and new hospitals.

(1) If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and denominator of which is 365. Within ~~30~~thirty (30) days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment

calculation must be submitted to OHCA by September 30 of each year.

(g) Disbursement of payment to hospitals.

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of the inpatient supplemental payment pool as reduced by payments distributed in paragraph (1) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(C) Directed payments paid through a managed care organization (MCO) as approved in the CMS-approved 438.6(c) directed payment pre-prints.

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(C) Directed payments paid through a managed care organization (MCO) as approved in the CMS-approved 438.6(c) directed payment pre-prints.

(3) Medicaid payments to a group of facilities within approved categories may not exceed the upper payment limit in accordance with 42 ~~CFR~~C.F.R. 447.272 (b) (2) and 42 ~~CFR~~C.F.R. 447.321 (b) (2). If any audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed based on the following methods:

(A) If it is determined prior to issuance of hospital access payments that the pool of hospitals would exceed the upper payment limit estimate of that pool, the amount above the UPL estimate will be allocated to another pool of hospitals that does not exceed the upper payment limit estimate of that pool. The reallocation can be applied to multiple pools if necessary.

(B) If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

(4) ~~In order to ensure sufficient funds to make payments effective July 1, 2013 OHCA shall reduce the next quarterly payment by 1.4% (OHCA will pay out 23.6% of the assessment~~

~~rather than 25%). This reduction will be distributed in the fourth (4th) quarter of the year as soon as all assessments are received. This payment will also be increased by penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are received prior to the 4th quarterly payment being processed the 4th quarter may be adjusted to pay out 26.4% plus accrued penalties.~~

(5) Effective for all subsequent calendar years the OHCA will distribute payments in the following quarterly percentages: 23.6%, 25%, 25%, 25%. A ~~5th~~fifth (5th) payment of 1.4% in the fourth (4th) quarter of each calendar year will also be made as soon as all assessments are received. ~~This payment will also be increased by any penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are received prior to the 4th quarterly payment being processed the 4th quarter payment may be adjusted to pay out 26.4% plus accrued penalties.~~

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN- ELIGIBILITY

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

(a) Adults with disabilities or long-term illnesses, members with intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least nineteen (19) years of age.

(2) He/she must reside in a nursing facility or a qualified long term care facility, or a public or private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for at least ~~ninety (90)~~sixty (60) consecutive days prior to the proposed transition date. If any portion of the ~~ninety (90)~~sixty (60) days includes time in a skilled nursing facility, those days cannot be counted toward the ~~ninety (90)~~sixty (60) day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one (1) day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four (4) unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

(8) He/she must not be a resident of a nursing facility or ICF/IID in lieu of incarceration.

~~(b) Youth ages sixteen (16) through eighteen (18) are eligible to transition back into the community from a psychiatric residential treatment facility (PRTF) through the Living Choice program if they meet the following criteria:~~

~~(1) Have been in a PRTF facility for ninety (90) or more days during an episode of care; and~~

~~(2) Meet Level 3 criteria on the Individual Client Assessment Record; or~~

~~(3) Meet the criteria for Serious Emotional Disturbance as defined in OAC 317:30-5-240.1; or~~

~~(4) Show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales).~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

317:30-5-1101. I/T/U Shared Savings Program

(a) Description. In accordance with state and federal law, the I/T/U Shared Savings Program is a program that direct the reinvestment of any savings to the Oklahoma Health Care Authority (OHCA) generated by enhanced federal matching authorized under Section 1905(b) of the Social Security Act at a rate of one hundred percent (100%) for covered services received through participating Indian Health Service, Tribal and Urban Indian (I/T/U) facilities.

(1) Eligibility. Authorized services provided by a non-I/T/U Medicaid provider to an American Indian or Alaska Native (AI/AN) Medicaid member as a result of a referral from an I/T/U facility provider may be eligible for the enhanced federal matching rate of one hundred percent (100%).

(2) Distribution criteria. OHCA will distribute up to fifty percent (50%) of any savings that result from the I/T/U Shared Savings Program to the referring I/T/U, but only after administrative costs incurred by OHCA in implementing the program have been fully satisfied. Distributions issued will ensure the following:

(A) Distributions to participating I/T/U facilities will be used to increase care coordination and to support health care initiatives for AI/AN populations;

(B) OHCA will deposit any shared savings that remain after administrative costs have been fully paid, and after distributions have been made to participating I/T/U facilities, into the I/T/U Shared Savings Revolving Fund for the purpose of increasing Medicaid provider rates;

(C) Monies in the fund will not be used to replace other general revenues appropriated and funded by the Oklahoma Legislature or other revenues used to support Medicaid; or

(D) OHCA will make distributions on a quarterly basis to participating I/T/U facilities based on claims data. The calculation will include the paid claims from the non-I/T/U provider that a member was referred to by an I/T/U. The referring ITU provider will need to be listed on the claim, and there must be an active Care Coordination Agreement (CCA) on file with OHCA. A CCA must be executed between the I/T/U facility and the non-I/T/U provider. A CCA must include, but not limited to the following:

(i) The I/T/U facility provider providing a request for specific services by electronic or other verifiable means and relevant information about the practitioner's member to the non-I/T/U provider;

(ii) The non-I/T/U provider sending information about the care the non-I/T/U provider provides to the patient including the results of any screening, diagnostic or treatment procedures, to the I/T/U facility provider;

(iii) The I/T/U facility provider continuing to assume responsibility for the member's care by assessing the information and taking appropriate action including, when necessary, furnishing or requesting additional services; and

(iv) The I/T/U facility incorporating the member's information in the medical record through the statewide health information exchange or other agreed-upon means.

(b) I/T/U Shared Savings Revolving Fund. A revolving fund for OHCA will be designated as the "I/T/U Shared Savings Revolving Fund". All monies accruing to the credit of the fund will be budgeted and expended by OHCA and will consist of:

(1) All monies received by OHCA as pursuant to Title 63 Section 5061.2 of the Oklahoma Statutes, and as otherwise specified or authorized by other state and federal laws;

(2) All monies accruing to the credit of the fund are appropriated and will be budgeted and expended by OHCA to increase Medicaid provider rates, unless otherwise provided by state and federal law; and

(3) Expenditures from the fund will be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services (OMES) for approval and payment.

(c) Report Criteria. An annual report will be prepared by the OHCA's Chief Financial Officer (CFO) and will be submitted to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives no later than thirty (30) days following the end of each state fiscal year. The annual report will account for:

(1) The savings realized by the OHCA as a result of the I/T/U Shared Savings Program;

(2) The administrative costs incurred by the OHCA as a result of the I/T/U Shared Savings Program;

(3) The monies distributed to participating I/T/U facilities as a result of I/T/U Shared Savings Program including, but not limited to, a summary of all specific distributions;

(4) The balance of savings realized by the OHCA as a result of the I/T/U Shared Savings Program and accruing to the credit of the fund after payment of administrative costs and distributions to participating I/T/U facilities; and

(5) The monies expended on increasing Medicaid provider rates including, but not limited to, identification of the types of providers affected and the percentage by which the providers' rates were increased.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 10. PURCHASING**

317:10-1-1. Purpose

~~(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the OHCA. These divisions provide the mechanism for the acquisition of goods, equipment, non professional and professional services for the operation of the OHCA. These rules are superseded by the Office of Management and Enterprise Services (OMES) Purchasing rules (OAC 260:115) whenever OMES has final authority on an acquisition.~~

~~(b) Different rules apply depending on which of the above three entities is making the acquisition and whether the purchase is for professional services or non professional services and products. When an acquisition is made by OMES, the OMES Purchasing rules at OAC 260:115 apply. When an acquisition is made by OHCA, these rules must be read in conjunction with the OMES rules.~~

(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA), as directed by 74 O.S. § 85.39. OHCA maintains two (2) internal units that are responsible for the acquisition of goods, equipment, non-professional services, and professional services for the operation of OHCA.

(b) The rules of this Chapter are superseded by the Office of Management and Enterprise Services (OMES) [Oklahoma Administrative Code (OAC) 260:115,] as amended from time to time, whenever OMES has final authority on an acquisition. When an acquisition is made by OMES, the OMES purchasing rules at OAC 260:115 apply. When an acquisition is made by OHCA, the rules of this Chapter should be read in conjunction with the OMES rules.

317:10-1-2. Definitions

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

~~"**Authority Board**" means the board designated by the Oklahoma Legislature to establish policies and adopt and promulgate rules for the OHCA.~~

~~"**Chief Executive Officer**" or "**CEO**" means the highest ranking administrator at the OHCA.~~

"**Acquisition**" means items, products, materials, supplies, services, and equipment that OHCA acquires by purchase, lease-purchase, lease with option to purchase, or rental.

"**Administrative review**" means the process by which OHCA ensures that a bid submission is complete and accurate; confirms that the bidder understood the solicitation specifications; and ascertains that all materials and any required signatures are submitted.

"**Award**" or "**contract award**" means the process by which OHCA formally notifies a bidder that OHCA has accepted the bidder's bid or offer.

"**Best and final offer**" or "**BAFO**" means a final offer submitted in writing by a bidder initially or after negotiations are completed and containing the bidder's most favorable terms for price, service, and/or products to be delivered.

"**Best price**" means the lowest available price for the goods and/or services that are subject of a solicitation.

"**Best value**" means evaluation criteria which may include but is not limited to the acquisition's operational cost a state agency would incur; the quality of the acquisition, or its technical competency; the reliability of the bidder's delivery and implementation schedules; the acquisition's facilitation of data transfer and systems integration; the acquisition's warranties and guarantees and the bidder's return policy; the bidder's financial stability; the acquisition's

adherence to the state agency's planning documents and announced strategic program; the bidder's industry and program experience and record of successful past performance with acquisitions of this complexity; the anticipated acceptance by user groups; and the acquisition's use of proven development methodology, and innovative use of current technologies.

"Bid" means any response to a solicitation, including any and all required forms; required documents and information; and supplemental documents and information.

"Bidder" means an individual, entity, or service vendor that submits a bid in response to a solicitation.

"Bid evaluation" means the process of conducting any evaluative activity that could reasonably be expected to result in determining the value, nature, character, or quality of a bid.

"Bid evaluator" means an employee or officer of the State of Oklahoma who is actively engaged in Oklahoma Health Care Authority's (OHCA) process to evaluate, score, or select a bid, regardless of whether a contract is awarded to the bid evaluated and/or scored by that employee or officer.

"Bid specifications" means the information OHCA will use for bid evaluation, when such information is exactly detailed within a solicitation and is based on the subject matter of the solicitation, the type of solicitation, and the needs to be met by the supplier(s) awarded a contract from the solicitation.

"Central Purchasing Division" means the Central Purchasing Division of the Office of Management and Enterprise Services (OMES).

"Certification" means the process of a bidder providing OHCA with an official document attesting to a status or level of achievement in response to a solicitation.

"Certified Procurement Officer" or "CPO" means a state agency procurement official certified as a procurement officer or analyst by the State Purchasing Director under the provisions of the Oklahoma Central Purchasing Act.

"C.F.R." means the Code of Federal Regulations as may be amended from time to time.

"Chief Executive Officer" or "CEO" means the highest-ranking administrator at the OHCA.

"Chief Information Officer" means the chief administrative officer of the Information Services Division of the Office of Management and Enterprise Services.

"Clarification" means a bidder's explanation of all or part of a bid that does not change, alter, or supplement the bid.

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

"Closing date/time" means the date and Central Time a solicitation specifies responses must be received by OHCA.

"Competitive solicitation" or "solicitation" means an invitation to bid for the provision of goods or services through specified documents submitted to the Central Purchasing Division or a state agency pursuant to terms, conditions, and other requirements of a solicitation. The competitive solicitation process may be electronic when the terms of the solicitation expressly permit electronic submission and the requirements of applicable statutes and rules are met. When used in this chapter, "competitive solicitation" is synonymous with "invitation to bid," "request for proposal," "request for information," or "request for quotation."

"Conflict plan" means the written statement detailing the accommodations and/or remedies associated with a specific OHCA employee's or officer's conflict of interest in the procurement process or resulting contract.

"Conflict of interest" means a situation in which a person is in a position to derive personal benefit from actions or decisions made in their official capacity, a situation in which the concerns

or aims of two (2) different parties are incompatible, a situation prohibited or constrained by law, or a situation that would appear inappropriate to a reasonable individual.

"Contract" means the written and binding agreement between OHCA and the bidder resulting from the competitive solicitation.

"Contracting official" or "contracting officer" means the OHCA CEO or the OHCA officer or employee to whom contracting authority has been delegated by the OHCA CEO, unless specified otherwise.

"Contractor" means any individual or entity contracted with OHCA for the provision of any goods or services. A bidder becomes a contractor upon contract award and execution.

"Days" means calendar days unless otherwise specified.

"Debar" or "debarment" means action taken by the State Purchasing Director to exclude any business entity from inclusion on the Supplier List, bidding, offering to bid, receiving an award of contract with the state of Oklahoma for acquisitions by state agencies, or a contract the OMES awards or administers. Debarment may also result in cancellation of existing contracts with the State of Oklahoma.

"Employee" or "officer" means a natural person that works for OHCA, unless otherwise specified, regardless of title or designation and regardless of manner of appointment, election, or hiring. "Employee or officer" does not mean a member of the Authority Board in the member's capacity as a board member.

"Enrollment activities" means activities performed or conducted by OHCA related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling, including by algorithm, Medicaid beneficiaries with respect to any health plan or managed care services contract.

"Fiscal year" means the period of time from July 1 of a calendar year through June 30 of the succeeding calendar year.

"Former employee" means a natural person whose work as an employee or officer for OHCA ended by any means at some point prior to the currently referenced moment.

"Health plan" means any person or entity that is licensed as a health maintenance organization (HMO) by the state of Oklahoma to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma Medicaid State Plan and that contracts with the State to provide services to enrollees.

"Invoice" means an accounting document issued by an individual or entity that details the goods and/or services provided and the amount of money owed for the goods and/or services when the document conforms to all invoicing provisions of the contract and that records the details of the transaction.

"Managed care entity" or "MCE" means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization (MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).

"Managed care organization" or "MCO" means the same in these rules as defined at 42 C.F.R. § 438.2.

"Managed care program" or "managed care" or "MCP" means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"Mandatory specification" means any specification of a solicitation when the terms "shall", "must", "will", or "is required" are used to describe, define, or announce the specification. This definition refers only to the use of such words in a solicitation and does not refer to the use of such words in this chapter.

"Material deficiency" or "material deviation" means a bidder's failure to provide information necessary to evaluate a competitive solicitation.

"Medicaid" means the medical assistance program jointly administered by the federal and state governments and authorized by 42 U.S.C. § 1396a to provide health care benefits for certain low-income persons.

"Minor deficiency" or "minor informality" means an immaterial defect in a bid or variation in a bid from the exact requirements of a competitive solicitation that may be corrected or waived without prejudice to other bidders. A minor deficiency or informality does not affect the price, quantity, quality, delivery, or conformance to specifications and is negligible in comparison to the total cost or scope of the acquisition.

"Multi-award" means the process by which OHCA formally, by written determination, notifies two or more bidders that OHCA has accepted the bidders' bid to furnish an indefinite quantity or category of item, where more than one supplier is needed to meet the contract requirements for quantity, delivery, service, or product compatibility.

"Non-collusion certification" means a certification submitted by a bidder with any competitive bid or contract executed by the state for goods or services in accordance with 74 O.S. § 85.22.

"Nonresponsive" means a bid or proposal that has been determined not to conform to essential requirements of a solicitation.

"OAC" means the Oklahoma Administrative Code as may be amended from time to time.

"Office of Management and Enterprise Services" or "Office" or "OMES" means the Oklahoma Office of Management and Enterprise Services.

"Oklahoma Central Purchasing Act" means 74 O.S. §§ 85.1 et seq.

"Oklahoma Health Care Authority" or "OHCA" or "Authority" means the single state agency designated to administer the medical programs which make available appropriate medical services to eligible individuals through the Title XIX Medicaid Program and which has authority to procure, administer and monitor contracts, issue performance deficiency notices, and assess non-compliance damages.

"OHCA Board" means the board designated by the Oklahoma Legislature to establish policies and adopt and promulgate rules for the OHCA.

"Oklahoma Information Technology (IT) Accessibility Standards" or "IT Accessibility Standards" means the accessibility standards adopted by the Office of Management and Enterprise Services (Reference OAC 250:15) to address all technical standard categories of Section 508 of the Rehabilitation Act (Reference 29 U.S.C. § 794d), as amended by the Workforce Investment Act of 1998 (Reference P.L. 105-220, August 7, 1998) and adopted at 62 O.S. §§ 34.28, 34.29, 34.30, and 34.16, to be used by each state agency in procuring, maintaining, or using information technology, and in the development and implementation of custom-designed information technology systems, web sites, and other emerging information technology systems.

"Oral presentation evaluation" means the process, through the bidder's participation in an interactive dialogue or non-interactive presentation, by which OHCA assesses a bidder's capability, past performance, work plans or approaches, staffing resources, transition plans, sample tasks, or fit with the OHCA.

"O.S." or "Okla. Stat." means the Oklahoma Statutes as may be amended from time to time.

"Permissible specification" means any specification in a solicitation when the terms "can", "may", or "should" are used to describe, define, or announce the specification. This definition refers only to the use of such words in a solicitation and does not refer to the use of such words in this chapter.

"Privatize" means to enter into contract for the performance of a duty or function which is currently being performed by a state employee.

"Procurement" means buying, purchasing, renting, leasing, or otherwise acquiring any goods or services. The term also means all functions that pertain to the obtaining of any goods or services, including but not limited to the description of requirements, selection, and solicitation of sources, preparation and award of contracts, and all phases of contract administration.

"Professional services" means services which are predominantly advisory or intellectual in character, involve privatized functions, or involve support rather than supplying equipment, supplies, or other merchandise. Professional services include those services requiring special, usually advanced, education, or skill.

"Prejudice" means the effect on an affected bidder's substantial rights when a procurement decision related to a different bidder, if such decision is found to be in error, would yield a more favorable result for the affected bidder if the decision error were corrected.

"Purchasing" means the Purchasing Department of the Oklahoma Health Care Authority.

"Purchasing manager" means the Purchasing Manager of the Oklahoma Health Care Authority.

"Registered supplier" means a supplier that registers with the Central Purchasing Division pursuant to 74 O.S. § 85.33.

"Remedy" means to cure, alter, correct, or change.

"Request for information" or "RFI" means a non-binding procurement practice used to obtain information, comments, and feedback from interested parties or potential suppliers prior to issuing a solicitation.

"Request for proposal" or "RFP" means a type of solicitation OHCA or the State Purchasing Director issues to suppliers to request submission of proposals for acquisitions.

"Request for quotation" or "RFQ" means a simplified written or oral solicitation OHCA or the State Purchasing Director issues to suppliers to request submission of a quote for acquisitions.

"Requisition number" means an identifier OHCA or OMES assigns to a requisition.

"Responsible supplier" means a supplier who demonstrates capabilities, in all respects, to fully perform the requirements of a contract and which will ensure good faith performance, including but not limited to finances, credit history, experience, integrity, perseverance, reliability, capacity, facilities and equipment, and performance history.

"Responsive" means a bid or proposal that has been determined to conform to the essential requirements of a solicitation.

"Risk contract" means a contract between OHCA and a managed care organization (MCO), 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.

"Sole brand acquisition" means an acquisition that by specification restricts the acquisition to one manufacturer or brand name.

"Sole source acquisition" means an acquisition that by specification restricts the acquisition to one supplier.

"Split purchase" means dividing a known quantity or failing to consolidate a known quantity of an acquisition for the purpose of evading a competitive bidding requirement.

"State Purchasing Director" means the director of the Central Purchasing Division of the Office of Management and Enterprise Services appointed by the OMES Director and includes any employee or agent of the State Purchasing Director, acting within the scope of delegated authority. (Reference 74 O.S. § 85.2) Unless otherwise stated, the term includes employees of the Central Purchasing Division and state agency purchasing officials certified by the State Purchasing Director to which the State Purchasing Director has lawfully delegated authority to act on his or her behalf. In regard to the procurement of information technology or telecommunications, the term means the Chief Information Officer of the Office of Management and Enterprise Services.

"Statement of work" or "scope of work" means a detailed description of the work which OHCA requires a contractor or supplier to perform or accomplish.

"Supplier" or "vendor" means an individual or business entity that sells or desires to sell acquisitions, including goods and/or services to OHCA. (Reference 74 O.S. § 85.2)

"Supplier list" means a list of individuals or business entities that have registered with the Central Purchasing Division in order to receive notification of solicitations for commodities specified in their registration application.

"Supplier performance evaluation" means information a state agency or OMES Procurement provides to the State Purchasing Director, in a manner the OMES Director prescribes, that documents the quality of service or products provided by a supplier.

"Supplier registration" means a process a supplier uses to register with the Central Purchasing Division to automatically receive solicitations based on a commodity class for a specified period of time.

"Technical proposal evaluation" means the process, based on established criteria and reliant on evaluators' expertise in assessing the strengths and weaknesses of multiple bids, by which OHCA measures the extent to which a bid will meet OHCA's needs.

"U.S.C." means the United States Code as may be amended from time to time.

"Value based" or "value-based purchasing" means the intentional linking of cost to the OHCA's perception of the value of goods or services. In a health plan or managed care contract, these terms refer to provider payments made by the health plan or managed care entity based on improved performance by health care providers.

317:10-1-12. Protest of award

(a) Protests of awards made by ~~the Authority~~OHCA under 74 Okla. Stat. § ~~85.5T~~85.5N are addressed at OAC 317:2-1-1 et seq.

(b) Bidders who wish to protest any other award shall follow the process outlined in the ~~Office of Management and Enterprise Services~~OMES rules at OAC 260:115-3-19.

317:10-1-16. Delegation of authority

The authority to procure needed products and services for ~~the Authority~~OHCA has been delegated to ~~the Authority~~OHCA from the Office of Management and Enterprise Services, Central Purchasing Division. The ~~Authority~~OHCA Board delegates authority for expenditure of funds to the CEO and other ~~Authority~~OHCA officers and personnel according to the dollar limits and types of products stated in (1), (2) and (3) of this Section. Within this authority, the CEO may delegate in writing to other specific individuals the responsibility for the performance of the procurement duties.

(1) **Supply and non-professional services acquisitions.** Each division director or supervisor may initiate any supply or non-professional services acquisition which is within his or her authorized division budget and approved by the CEO or designee. ~~Any single acquisition of this kind over \$5,000 up to \$500,000 must be approved by the CEO, Executive Staff or designee.~~ Any single acquisition of this kind over ~~\$500,000~~\$1,000,000 must be approved by the ~~Authority~~OHCA Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds ~~\$500,000~~\$1,000,000 for a supply or non-professional services contract must be prior approved by the ~~Authority~~OHCA Board. Any amendment to a contract that would result in a ~~40 percent~~ten percent (10%) or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval.

(2) **Professional service contracts.** Acquisitions of professional services must be approved by the CEO or designee. All professional service contracts over ~~\$125,000~~\$1,000,000 must be approved by the ~~Authority~~OHCA Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds ~~\$125,000~~\$1,000,000 for a professional service contract must be prior approved by the ~~Authority~~OHCA Board. Any amendment to a contract that would result in a ~~25 percent~~twenty-five percent (25%) or greater increase or a ~~\$250,000~~\$1,000,000 or greater increase in the total acquisition cost originally approved by the ~~Authority~~OHCA Board must be submitted to the ~~Authority~~OHCA Board for prior approval. Board approval is not required if the increase in total contract acquisition cost results from the exercise of a price increase methodology, option for additional work, or option to renew that was contained in the previously approved contract.

(3) **Interagency/intergovernmental agreements.** All agreements with another state agency or public agency must be approved by the CEO or designee, but are exempt from the ~~Authority~~OHCA Board approval.

317:10-1-21. Procurement ethics, prohibited conduct

(a) Standard of conduct. The Oklahoma Central Purchasing Act, State Ethics Commission rules, and other state laws contain regulations, prohibitions, and penalties governing procurement ethics. Transactions relating to the public expenditure of funds require the highest degree of public trust and impeccable standards of conduct.

(b) One (1) year prohibition on certain contracts. For one (1) year after the employment termination date of any employee or officer, OHCA is prohibited from entering into a sole source contract, a professional service contract, or a contract for the services of that employee or officer. Refer to 74 O.S. § 85.42(A). An agency may enter into a sole source contract or a contract for professional services at any time with a person who is a qualified interpreter for the deaf. Reference to 74 O.S. § 85.42(D).

(c) Supplier gratuities. Employees or officers of the Purchasing and Contracts Development unit, acting within the scope of delegated authority, or any member of their immediate family, under the Oklahoma Central Purchasing Act shall not accept any gift, donation, or gratuity for himself or any member of his immediate family from any supplier or prospective supplier of any acquisition covered by the Oklahoma Central Purchasing Act. This subsection shall not apply to exceptions to the definition of "anything of value" established in rules promulgated by the Oklahoma Ethics Commission.

(d) State requirement for one (1) year prohibition on certain state officers' or employees' employment with a supplier. For a period of one (1) year from the date that any contract to privatize is awarded by OHCA, any state officer or employee who exercised discretionary or

decision-making authority in awarding a specific contract to privatize is prohibited from becoming an officer or employee of a business organization which is party to that specific contract to privatize. If, within the prohibited period and in violation of state law, any state officer or employee who exercised discretionary or decision-making authority in awarding a specific contract to privatize becomes an officer or employee of a business organization which is party to that specific contract to privatize, then the business organization is prohibited from contracting with OHCA for one (1) year from the date of the violation of state law. Refer to 74 O.S. § 590.

(e) **Agency contract or agreement open for legislative inspection.** Upon request, a contract or any other form of agreement made by OHCA will be open for inspection to any member of the Legislature. OHCA will not direct, put in a contract, or in any way disallow a vendor, client, employer or independent contractor, person, or any other entity from contacting or communicating with any member of the Legislature. Refer to 74 O.S. § 464.1.

(f) **Federal requirement for conflict-of-interest safeguards pertaining to any contract for health plan or managed care services.** Any contract awarded for health plan or managed care services and subject to 42 C.F.R. Part 438 necessitates state conflict-of-interest safeguards at least as effective as those specified at section 27 of the Office of Federal Procurement Policy Act. Refer to 42 C.F.R. § 438.58, citing 41 U.S.C. § 423. In addition to this subsection, OAC 317:10-1-22 describes processes pertaining to the conflict-of-interest safeguards in this section.

(1) The following person(s) shall not, except as provided by law, knowingly disclose a contractor bid or proposal information or source selection information before the award of an OHCA procurement contract to which the information relates:

(A) When such person is:

(i) A present or former employee or officer;

(ii) Acting or has acted for or on behalf of OHCA with respect to a procurement; or

(iii) Advising or has advised OHCA with respect to a procurement; and

(B) By virtue of that office, employment, or relationship has or had access to contractor bid or proposal information or source selection information.

(2) A person shall not, other than as provided by law, knowingly obtain contractor bid or proposal information or source selection information before the award of an OHCA procurement contract to which the information relates.

(3) If an employee or officer who is personally and substantially participating in a procurement under this Section, contacts or is contacted by a procurement bidder regarding possible non-OHCA employment, the employee or officer shall promptly report the contact in writing to the employee's or official's supervisor and to the designated OHCA ethics official (or designee) and either:

(A) Reject the possibility of non-OHCA employment; or

(B) Disqualify himself or herself from further personal and substantial participation in that procurement until such time as OHCA has authorized the employee or official to resume participation in such procurement on the grounds that:

(i) The bidder is no longer a participant in the procurement; or

(ii) All discussions with the bidder regarding possible non-OHCA employment have terminated without an agreement or arrangement for employment.

(4) A former employee or officer shall not accept compensation from a contract-awarded bidder as an employee, officer, director, or consultant of that bidder within a period of one (1) year after such former employee or officer functioned within the scope of employment as:

(A) The procuring contracting officer, the source selection authority, a member of an evaluation committee, or the chief of a financial or technical evaluation team in a

procurement in which that contract-awarded bidder was selected for award of a contract in excess of \$10,000,000;

(B) A program manager, deputy program manager, or administrative contracting officer for a contract in excess of \$10,000,000 awarded to that contract-awarded bidder; or

(C) A primary decision maker who personally made one (1) or more of the following decisions on behalf of OHCA:

(i) To award a contract, subcontract, modification of a contract or subcontract, or a task order or delivery order for that contract-awarded bidder valued in excess of \$10,000,000;

(ii) To establish overhead or other rates applicable to a contract or contracts for that contract-awarded bidder valued in excess of \$10,000,000;

(iii) To approve issuance of a contract payment or payments to that contract-awarded bidder valued in excess of \$10,000,000; or

(iv) to pay or settle a claim in excess of \$10,000,000 with that contract-awarded bidder.

(5) A former employee or officer who accepts compensation from any division or affiliate of a contract-awarded bidder that does not produce the same or similar products or services as the entity of the contract-awarded bidder that is responsible for the contract does not violate this section.

(6) With regard to any current or former employee or officer or any bidder who violates this subsection (f), OHCA may take any administrative action and pursue any penalty allowed by state or federal law.

(7) Any employee or officer or former employee or officer may request advice from the appropriate designated OHCA ethics official regarding whether the employee or officer or former employee or officer is or would be precluded by subsection (f)(4) of this section from accepting compensation from a particular contractor.

317:10-1-22. Conflicts of interest

(a) **Types of conflicts of interest.** Three (3) types of conflict-of-interest forms may be used for OHCA to clear conflicts related to procurement.

(1) **General conflicts of interest.** OHCA requires all employees or officers to sign general conflict-of-interest forms annually.

(2) **Contract-specific conflicts of interest.** OHCA requires specific employees or officers, as described within this subsection, to sign a contract-specific conflict-of-interest form related to a specific contract when deemed appropriate to meet any applicable federal or state law or regulation and to avoid impropriety or the appearance of impropriety in connection with the procurement process or the administration of the specific contract. The contract-specific conflict-of-interest form will inform the employee or officer of rights and responsibilities related of role as related to a specific contract, including any potential restrictions on future employment or other business connections with the contractor or with OHCA, and will record any conflicts that pre-date the signing of the form or that arise at any point in time thereafter until the contract is terminated.

(3) **Evaluator-specific conflicts of interest.** OHCA requires employees or officers of any agency or department of the State to sign an evaluator-specific conflict-of-interest form, whenever the employee or officer is appointed, selected, or approved as a bid evaluator or performs any duty of a bid evaluator for a specific contract. The evaluator-specific conflict-of-interest form will inform the employee or officer of rights and responsibilities related to the role of bid evaluator, including any potential restrictions on future employment or other

business connection with the contractor or with OHCA, and will record any conflicts that pre-date the signing of the form or that arise at any point in time thereafter until the evaluation is complete and closed. If a bid evaluator is removed from the bid evaluation for any reason, including potential conflict of interest, a substitute bid evaluator with similar expertise will be added to the bid evaluation after signing an evaluator-specific conflict-of-interest form.

(b) Forms meet or exceed legal standards. All conflict-of-interest forms shall meet or exceed the applicable legal standards controlling the type of contract and/or type of employee or officer involvement in procurement or administration of a contract, including but not limited to 74 O.S. § 85.42(A), 74 O.S. § 590, and 41 U.S.C. § 423.

(c) Identification of conflicts of interest. OHCA will identify conflicts of interest, plan any accommodation, and manage any employee disciplinary action.

(1) The OHCA contracting officer will identify all employee or officer positions required to sign a specific conflict-of-interest form or an evaluator-specific conflict of interest form. For any solicitation for health plan or managed care services, the contracting officer will identify, at minimum, all employees or officers engaged in enrollment activities, when those employees or officers are internally titled manager or above, and all employees and officers engaged as bid evaluators.

(2) OHCA's Human Resources (HR) Department will obtain conflict-of-interest forms:

(A) For general conflict-of-interest forms, from each employee or officer at the time of hiring and annually thereafter.

(B) For contract-specific conflict-of-interest forms, from each employee or officer in an identified position prior to the employee's or officer's participation in contract- or solicitation-specific activities.

(C) For evaluator-specific conflict-of-interest forms, from each employee or officer identified as an evaluator prior to the employee's or officer's participation in evaluation-specific activities.

(3) OHCA HR and OHCA's Legal Department will review the executed conflict-of-interest forms.

(4) If a potential conflict is identified, a conflict plan will be presented to the employee or officer. The conflict plan will include, at minimum, guidelines that the employee or officer must follow to avoid an actual conflict.

(5) The employee or officer will determine if the conflict plan can be accommodated and respond accordingly.

(6) If the accommodation does not resolve the issue, then the employee or officer will face disciplinary action up to and including termination of employment.

(d) Each employee or officer has a responsibility to notify OHCA HR within one (1) business day of becoming aware of a potential conflict, regardless of whether the employee or officer previously executed a conflict-of-interest form. Upon notification, OHCA HR will take appropriate action to identify the potential conflict in writing, either as part of the existing conflict-of-interest form or as a new conflict-of-interest form; develop a conflict plan; and present the conflict plan to the employee or officer.

317:10-1-23. Value-based purchasing

(a) Unless otherwise prohibited by law, OHCA may engage in value-based purchasing with regard to any contract for goods, services, or professional services.

(b) Unless otherwise prohibited by law, OHCA may include in any contract for health plan or managed care services any concept of value-based purchasing as to the transaction between OHCA and the health plan or managed care entity.

(c) Unless otherwise prohibited by law, OHCA may include in any contract for health plan or managed care services any concept of value-based purchasing as to the transaction underlying the provision of health care services or items by providers contracted with any health plan or managed care entity.

317:10-1-24. Bidder obligations arising from bid submission

(a) **One (1) bid.** Bidders may submit only one bid in response to any solicitation. Except as requested by OHCA, no bid may be changed after the response due date and time. If the bidder needs to change a submitted bid prior to the response due date and time, the bidder will withdraw the originally submitted bid and submit a new bid to OHCA by the response date and time. Bidders may withdraw and resubmit a bid at any time prior to the submission deadline. As part of the resubmission process, the bidder will acknowledge in writing that the resubmitted bid supersedes all previously submitted bids by including the following statement on the superseding bid cover page, "This bid supersedes the bid previously submitted". In the body of the submission transfer, whether by email or otherwise, the resubmitted bid should contain the solicitation number and solicitation response due date and time.

(b) **Bidder duties.** The bidder shall submit any bid:

(1) In strict conformance with the instructions provided to bidders along with a completed "Responding Bidder Information" form and any other forms required by the solicitation;

(2) Electronically;

(3) With a completed certification statement, as described in the solicitation, that uses the bidder's legal name and has been executed by an authorized person with full knowledge and acceptance of all certificate provisions;

(4) According to the "Technical Proposal Requirements" of the solicitation;

(5) With relevant information for a designated contact to receive notice, approvals, and requests that are allowed or required by the terms of the solicitation;

(6) As firm, including a guarantee that unit prices are correct, for a minimum of one hundred eighty (180) days after the solicitation closing date; and

(7) In accordance with 74 O.S. § 85.40, requiring the bidder to include in the total bid price all travel expenses, including but not limited to transportation, lodging, and meals, to be incurred by a bidder in performance of the awarded contract.

(c) **Bidder's acknowledgements.** By submitting a bid, the bidder promises, acknowledges, and agrees that:

(1) The bidder will adhere to any additional terms OHCA deems necessary to the performance of the contract, including but not limited to terms related to the contractor's need to access, process, or store Medicaid beneficiary data;

(2) All costs incurred by a bidder in participating in the procurement process is the sole responsibility of the bidder, and the bidder will not be reimbursed for or awarded damages for such costs;

(3) If a bidder fails to notify the contracting officer of an ambiguity, conflict, discrepancy, omission, or other error in the procurement process or in any of the documents provided by OHCA that is known to the bidder, or that reasonably should be known by the bidder, the

bidder accepts the risk of submitting a bid and, if awarded the contract, will not be entitled to additional compensation, relief, or time by reason of the error or its later correction; and

(4) Bidder waives any error in the procurement process or documents which is known to the bidder or reasonably should have been known, and such error will not be the grounds of a bid protest.

(d) **Indemnification.** By submitting a bid, the bidder understands, accepts, acknowledges, and agrees to this paragraph in its entirety. OHCA will not indemnify a bidder, any subcontractor, or any other party to an awarded contract. Any contract between the selected bidder and OHCA will not contain any terms limiting the liability of the bidder or providing indemnification by OHCA in favor of the bidder or any third parties. The State of Oklahoma and its agencies do not hold an individual or a private entity harmless from liability or provide indemnity to a private entity or individual. Any attempt by the bidder to add indemnification or limitation of liability provisions in favor of the bidder or third parties to the definitive contract may render the bidder's bid nonresponsive and subject to rejection. Should OHCA accept a bid that attempts to add indemnification or limitation of liability provisions in favor of the bidder or third parties, such attempts are severable from the remainder of the bid and have no effect on any awarded contract. At no time and in no way will OHCA be deemed to have waived this paragraph through action or inaction.

(e) **Conflict of laws.** With regard to the procurement process to which a bid is submitted and any business relationship or contract resulting from such procurement process, by submitting a bid, the bidder understands, accepts, acknowledges, and agrees:

(1) That the undertaking and all matters arising out of or relating to the undertaking, including all protests, claims, causes of action, controversies, or matters in dispute between OHCA and the bidder—whether sounding in contract, tort, statute, regulation, or otherwise—shall be governed by, construed, interpreted, and enforced in accordance with the substantive and procedural laws of the State of Oklahoma, including its statutes of limitations, without giving effect to any choice of law or conflict of laws rules or provisions, whether of the State of Oklahoma or any other jurisdiction, that would cause the application of the laws of any jurisdiction other than the State of Oklahoma;

(2) To exclude application of the United Nations Convention on Contracts for the International Sale of Goods; and

(3) That a final judgment in any matter described in (e)(1) of this Section is conclusive and binding and may be enforced in any other jurisdiction.

317:10-1-25. Property of the state

Any bid, including all related and submitted documents and information, is part of the public record(s) and is subject to disclosure; unless otherwise specified in the Oklahoma Open Records Act, the Central Purchasing Act, or other applicable law. All material submitted by a bidder becomes the property of the State of Oklahoma upon submission and will be a matter of public record, subject to the procedures for treatment of proprietary information. OHCA has the right to use all concepts described in any bid, regardless of whether such bid is accepted. By any secured means, including electronic transmission via secure file transfer protocol, OHCA has the right to transmit all material submitted as part of or in connection with a bid, including proprietary information, to any professional services contractor then or afterward contracted with OHCA for provision of professional services related to the solicitation, award, or administration of the contract.

317:10-1-25.1. Proprietary or confidentiality claims

(a) Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information that a bidder submits as part of or in connection with a bid are public records and subject to disclosure after the contract has been awarded pursuant to OAC 260:115-3-9.

(1) No portion of a bid shall be considered confidential after award of the contract except, pursuant to 74 O.S. §85.10, information in the bid determined to be confidential by the State Purchasing Director or delegate.

(2) A properly submitted confidentiality claim of a potential awardee is reviewed and determined prior to award.

(3) A properly submitted confidentiality claim of a non-awarded bidder is reviewed and determined only when responding to an open records request concerning the bid.

(b) Among the parties to a solicitation, OHCA is the sole and final determiner of the proprietary or confidential nature of a bid in part or in whole.

(1) OHCA has no responsibility to independently review a bid, including any associated documentation or information, for a potential proprietary or confidentiality claim.

(2) OHCA will not consider a proprietary or confidentiality claim if a bid fails to comply with the requirements of this section, the solicitation, and applicable law, including OAC 260:115-3-9. Nonconforming bids will be subject to disclosure pursuant to State law.

(3) A bidder, who wishes to seek an exemption from disclosure under the Oklahoma Open Records Act or other statutory or regulatory requirements, is responsible for asserting any right of confidentiality that may exist. The OHCA will not assert a right of confidentiality on behalf of a bidder.

(c) To claim any portion of a bid as proprietary or confidential, the bidder will:

(1) Specifically identify what information is considered by the bidder to be confidential;

(2) Enumerate the specific grounds, based on applicable laws, which support treatment of the information as exempt from disclosure;

(3) Explain why disclosure is not in the best interest of the public if the information is incorporated into an awarded contract;

(4) Submit all information considered confidential under separate cover as described below;
and

(5) Include, for efficient evaluation, the content considered confidential in applicable sections of the bid.

(d) Any bidder with bid information the bidder considers confidential must submit an additional electronic copy of the bid with the claimed information redacted (marked out to be illegible). The additional copy must be clearly labeled "Redacted Copy." If the bidder provides a copy of its bid with proprietary and confidential information redacted and OHCA appropriately supplies the redacted bid to another party under the Oklahoma Open Records Act or other statutory or regulatory requirements, the bidder agrees to indemnify OHCA and to defend the bidder's interest in protecting the referenced redacted material.

(e) OHCA does not consider as confidential a bid marked in total as proprietary and/or confidential (versus specific documents or portions of documents within a bid). Likewise, unless specifically referenced otherwise in a solicitation, resumes, pricing, marketing materials, business references, additional terms proposed by a bidder, and subcontractor information are not confidential and are not exempt from disclosure under the Oklahoma Open Records Act. The foregoing list is not exhaustive but is intended to address information often marked confidential that is not exempt from disclosure.

(f) Subject to the provisions of subsections (a)-(e) above, bids will be open for public inspection following contract award.

317:10-1-26. Withdrawal from solicitation

(a) At any time prior to the submission deadline of any solicitation, a bidder may withdraw a bid and remove itself from consideration by providing written notification, in the form specified in OAC 260:115-3-13, to the OHCA sole point of contact as identified in the solicitation. OHCA does not permit a bidder to withdraw a bid after the response due date and time except as authorized by the OHCA CEO after the bidder provides sufficient proof that the bidder included a significant error in the bid.

(b) Unless properly withdrawn, the submitted bid is deemed to be a binding offer on the part of the bidder.

317:10-1-27. Binding bids

OHCA considers all bids to be firm representations that the responding bidder has carefully investigated and will comply with all OHCA and State terms and conditions relating to the solicitation. A bidder whose bid is accepted for evaluation will be bound by the terms of the solicitation and the contents of the bid for the duration of the solicitation. The bidder will be bound by the terms in its solicitation response unless or until OHCA instructs the bidder to perform any function reflected in the solicitation response in a modified way to the extent it does not substantially alter the specifications or statement of work as defined in the solicitation. Bidders awarded a contract will be governed foremost by applicable law, then by the terms of the solicitation, including any associated model contract, then by any non-rule policy documents created by OHCA for the purposes of interpreting and implementing contract terms.

317:10-1-28. Contracting officer's actions

(a) The contracting officer may reject a bid for any valid reason, including but not limited to those listed at OAC 260:115-7-32(8) and the bidder's:

(1) Failure to submit required information;

(2) Failure to submit the bid by the response date and time unless OHCA has authorized acceptance of bids due to a significant error or incident that occurred which affected the receipt of a bid, per OAC 260:115-3-11;

(3) Failure to comply with bidder instructions or solicitation requirements;

(4) Failure to meet any mandatory specification of the solicitation; however, failure to meet a permissible specification of the solicitation will not be a valid reason to reject a bid;

(5) Failure to submit the bid by the strict deadline as described by date and time within the solicitation; and

(6) Attempted or actual inclusion or imposition of terms or conditions that would modify the requirements of the solicitation, require OHCA to indemnify the bidder or a third party, or limit the bidder's liability.

(b) The contracting officer may take any reasonable action with regard to a solicitation, including but not limited to:

(1) Waiving minor irregularities in any bid if determined to be in the best interest of the State. If granted, a waiver will in no way modify the requirements of the solicitation or the obligations of bidders awarded contracts;

(2) Awarding a contract based on a solicitation and the bid of any selected bidder;

(3) Awarding the contract to more than one (1) bidder;

- (4) Rejecting any or all bids received, if deemed to be in the best interest of the State;
 - (5) Requesting clarification or correction of any bid;
 - (6) Amending any solicitation or any segment of any solicitation;
 - (7) Canceling any solicitation, if determined to be in the best interest of the State; or
 - (8) Discontinuing the solicitation process at any time prior to contract award.
- (c) The contracting officer may question the grade and quality of any acquisition delivered to the agency.
- (1) The contracting officer or delegate has sole discretion in determining whether the acquisition meets the grade and quality specified in the contract.
 - (2) If the acquisition fails to meet the contract-specified grade and/or quality, OHCA may take remedial action with the appropriate supplier. Refer to 74 O.S. § 85.6.

317:10-1-29. Deficiencies

In accordance with the OAC 260:115-7-32(10), OHCA has the right but is not required to waive minor deficiencies or informalities if OHCA determines the deficiencies or informalities do not prejudice another bidder. OHCA may also permit bidders to cure certain non-substantive deficiencies if there is sufficient time prior to the award of the contract.

317:10-1-30. Submission of questions

(a) A bidder may submit written questions by email only to the OHCA sole point of contact as designated in the solicitation and using the "Questions" form, in original format, included in the Bidder's Library.

(b) OHCA will provide written answers to all technical bid and price questions received on or before the dates specified in the solicitation for questions and answers. Answers will be made publicly available in the form of one or more solicitation amendments posted to the Bidder's Library. Only posted answers will be considered official and valid. A bidder will not rely upon, take any action upon, or make any decision based upon any verbal communication with any State employee.

317:10-1-31. Bidder's conference

OHCA may hold a bidder's conference at OHCA offices or virtually on the date and time specified in the solicitation. Additional information about the bidder's conference, if any, will be provided in advance of the session.

317:10-1-32. Bid evaluation

A responsive bid that is not otherwise rejected will proceed to bid evaluation, which will be conducted in accordance with the solicitation. Within any solicitation, the bid specifications for evaluation will be provided and will be based on the subject matter of the solicitation, the type of solicitation, and the needs to be met by the supplier(s) awarded a contract from the solicitation.

- (1) The bid evaluation may consist of one (1) or more evaluative activities, including but not limited to:
- (A) Best price review;
 - (B) Best value review;
 - (C) Certifications;
 - (D) Administrative review;
 - (E) Technical proposal evaluation;
 - (F) Oral presentation evaluation; and

(G) Any other activity that could reasonably be expected to result in determining the value, nature, character, or quality of the bid.

(2) Bids responding to request for quotation will be evaluated solely on a "best price" basis.

(3) Bids responding to request for proposal will be evaluated on a "best value" basis unless the request for proposal specifies otherwise.

(4) A bidder's past performance may be considered when evaluating a bid.

(5) No evaluator acting in their role as an evaluator will make any decision regarding procurement, including but not limited to which, if any, bidder(s) will or will not be awarded the contract, whether a bid will or will not be rejected, and whether a solicitation will be continued or canceled. Evaluators, individually or collectively, may provide bid evaluation information and recommendations to the contracting official. A record of evaluators' numeric scores of bids, made by evaluators individually or collectively, will be maintained as part of the acquisition file.

(6) The contracting official will make all decisions regarding the procurement, including but not limited to which, if any, bidder(s) will or will not be awarded the contract, whether a bid will or will not be rejected, and whether a solicitation will be continued or canceled.

317:10-1-33. Contract award

(a) **Time of award.** OHCA will not award a contract at the time of a bid opening but, if at all, only upon completion of the following:

(1) Bid evaluation;

(2) Documentation of evaluation on each bid;

(3) Determination of the lowest and best or best value bidder;

(4) Verification of Oklahoma and federal debarment status;

(5) Verification, pursuant to applicable provisions of law, that the supplier is registered with the Secretary of State and maintains appropriate franchise tax payment status pursuant to 68 O.S. §§ 1203 and 1204; and

(6) Completion of any award-related administrative tasks.

(b) **Award by item.** If the procurement documents do not specify an all or none bid, more than one (1) bidder may be awarded a contract by item or groups of items.

(c) **No contract award.** OHCA may refrain from awarding a contract during any solicitation when:

(1) No bid meets the requirements of the solicitation;

(2) All bids exceed fair market value for the acquisition;

(3) The bid price exceeds available funds available to OHCA;

(4) OHCA no longer requires the acquisition in the form or manner specified; or

(5) Not awarding the contract is determined to be in the best interest of the state.

(d) **Evaluation tie.** Whenever it is determined that two (2) or more bids are equal, the contracting officer will determine the successful bid by a coin toss.

(e) **Notification of successful bidder.** OHCA will notify the successful bidder(s), if any, within a reasonable time after determination of the contract award.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

SUBCHAPTER 1. ADMINISTRATIVE APPEALS

317:2-1-1. Purpose

The purpose of this Chapter is to describe the different types of ~~grievances~~administrative appeals addressed by the Oklahoma Health Care Authority (OHCA), consistent with the State fair hearing requirements set out in 42 Code of Federal Regulations (C.F.R.) Part 431, Subpart E. The rules explain the ~~step-by-step~~step-by-step processes that must be followed by a party seeking redress from the OHCA. The majority of hearings on eligibility issues for members are conducted by the Oklahoma Department of Human Services; and are not contained in this Chapter. Hearings will not be granted when the sole issue to be determined is a Federal or State law requiring an automatic change adversely affecting some or all members.

317:2-1-14. Contract award protest process

~~Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) § 85.5 (N) may protest the award of a contract under such solicitation.~~

- ~~(1) A supplier shall submit written notice to the OHCA Legal Division of a protest of an award of a contract by OHCA within ten (10) business days of contract award. The protest shall state supplier facts and reasons for protest.~~
- ~~(2) The OHCA Legal Division shall review the supplier's protest and contract award documents. Written notice of the decision to sustain or deny the supplier's protest will be sent to the supplier within ten (10) business days of receipt of supplier's written notice.~~
- ~~(3) If the OHCA Legal Division denies the supplier's protest, the supplier may request a hearing to administratively resolve the matter within thirty (30) calendar days of receipt of the written denial by filing a form LD-3 with the Docket Clerk.~~
- ~~(4) The process afforded the supplier will be the process found at Oklahoma Administrative Code 317:2-1-2(e).~~
- ~~(5) The Administrative Law Judge's decision will constitute the final administrative decision of the Oklahoma Health Care Authority.~~

(a) Protest process. Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) § 85.5 (N) may protest the award of a contract under such solicitation to the State Purchasing Director. All remedies available to suppliers through the sealed bid process pursuant to the Oklahoma Central Purchasing Act are also available to online bidders in an online bidding process.

(b) State Purchasing Director review and determination. The State Purchasing Director will review the supplier's protest and contract award documents.

- (1) The State Purchasing Director may determine to respond to the protest or delegate the responsibility to OHCA by written notice to OHCA.
- (2) The State Purchasing Director or OHCA, as applicable, will send to the supplier written notice of the decision to deny or sustain the protest within ten (10) business days of receipt of the protest.

(c) Supplier appeal of decision to deny protest. The supplier may appeal a denial of protest by the State Purchasing Director or OHCA to the Office of Management and Enterprise Services (OMES) Director.

- (1) The supplier will file such appeal, if at all, within ten (10) business days of the date of the State Purchasing Director's or OHCA's notice of denial pursuant to 75 O.S. § 309 et seq.
- (2) The OMES Director may enter an order staying contract performance upon such terms and conditions as the OMES Director determines to be proper. Any request for stay of contract performance must be made in writing and filed during the ten (10) business-day time period in which an appeal may be commenced to the OMES director. The OMES Director shall have continuing jurisdiction to modify any such orders made in connection with a stay during the pendency of the appeal as appropriate under the circumstances presented.
- (3) The OMES Director may hear the appeal or assign the supplier's appeal to an administrative law judge (ALJ) retained by OHCA.
- (4) Administrative hearings conducted by OMES will be conducted in accordance with the Administrative Procedures Act at 75 O.S. §§ 309 et seq., and the OMES director shall have all powers granted by law, including any powers delegated to an ALJ by this Section.
- (5) Whenever the appeal is assigned to an ALJ retained by OHCA, the ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ shall conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5 and provide proposed findings of fact and conclusions of law to the OMES director.
- (6) The OMES director or the ALJ, as applicable, will send written notice to the parties of the final order sustaining or denying the supplier's appeal.
- (7) The cost of actions necessary to process a supplier's appeal, together with any other expenses incurred due to the appeal, will be paid by OHCA.
- (8) Whenever the appeal is assigned to the ALJ retained by OHCA, the ALJ will:
 - (A) Establish a scheduling order;
 - (B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;
 - (C) Rule on all interlocutory motions;
 - (D) Require briefing of any or all issues;
 - (E) Conduct hearings in a forum and manner as determined by the ALJ;
 - (F) Rule on the admissibility of all evidence;
 - (G) Question witnesses;
 - (H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which will include:
 - (i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;
 - (ii) Excluding all testimony of an unresponsive or evasive witness; or
 - (iii) Expelling the person from further participation in the hearing;
 - (I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;
 - (J) Administer oaths or affirmations;
 - (K) Determine the location of the hearing and manner in which it will be conducted;
 - (L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;
 - (M) Recess and reconvene the hearing;
 - (N) Set and/or limit the time frame of the hearing;

(O) Make proposed findings of facts and conclusions of law to the OMES Director; and
(P) Recommend that the OMES Director deny the supplier's appeal or that the contract award be cancelled and rebid.

(d) **Supplier appeal of OMES Director decision to deny appeal.** If the OMES Director denies a supplier's appeal, the supplier may appeal pursuant to provisions of 75 O.S. §§ 309 et seq.

SUBCHAPTER 3. MEMBER GRIEVANCES AND APPEALS, PROVIDER COMPLAINTS, AND STATE FAIR HEARINGS IN MANAGED CARE

317:2-3-1. Definitions

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

"**Adverse benefit determination**" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated and in accordance with Title 36 of Oklahoma Statute (O.S.) § 6475.3.

"**Appeal**" means a review of an adverse benefit determination performed by a managed care entity or according to managed care law, regulations, and contracts.

"**Exigent circumstances**" means a situation in which a reasonable person applying the appropriate standard would consider a member's health condition to be urgent with identifiable harm that could reasonably be expected to occur if the requested health care service is not provided promptly. The appropriate standard requires the assessment of a member's health condition through application, at minimum, of established, accepted standards of medical practice. Evidence of the member's condition may be demonstrated by indications from the treating provider or from the member's medical record, including but not limited to such information as the member's diagnosis, symptoms, or test results.

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

"**Health plan**" means any person or entity that is licensed as a health maintenance organization (HMO) by the State of Oklahoma to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma State Medicaid Plan and that contracts with the State to provide services to enrollees. "Health plan" is synonymous with "health carrier".

"**Managed care entity**" or "**MCE**" means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization

(MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).

"Managed care organization" or "MCO" means the same in these rules as defined at 42 Code of Federal Regulations (C.F.R.) § 438.2.

"Managed care program" or "managed care" or "MCP" means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"Member" means an individual eligible for Medicaid in the State of Oklahoma, eligible for a managed care program, and enrolled in a managed care entity. "Member" is synonymous with "health plan enrollee".

"Prepaid ambulatory health plan" or "PAHP" means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prepaid inpatient health plan" or "PIHP" means the same in these rules as defined at 42 C.F.R. § 438.2.

"Primary care case management" or "PCCM" means the same in these rules as defined at 42 C.F.R. § 438.2.

"Primary care case management entity" or "PCCM entity" means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prior authorization (PA)" means a requirement that a member, through a provider, obtain the managed care entity'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. For purposes of these rules, "prior authorization" is included as a determination of health care services within the term "adverse benefit determination".

"Provider" means a health care or dental provider licensed or certified in this state.

317:2-3-2. Timeframes

(a) For the purpose of calculating a timeframe in this Subchapter, the date on the written notice is not included. The last day of the timeframe is included, unless the last day is a legal holiday, as defined by 25 Oklahoma Statutes (O.S.) § 82.1, or any other day OHCA is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(b) A grievance or appeal a member sends via mail is deemed filed on the date the MCE receives request.

(c) A request for reconsideration or appeal a provider sends via mail is deemed filed on the date the MCE receives the request.

(d) A request for State fair hearing by a member or provider is deemed filed on the date the OHCA receives the request.

317:2-3-3. Grievance and appeals system

In accordance with state and federal law, including but not limited to 63 Oklahoma Statutes (O.S.) § 7310 and 42 Code of Federal Regulations (C.F.R.) §§ 438.210, 431.213-14, 438.402, 438.404, 438.408, and 438.410, each MCE will have an established grievance and appeals system by which to receive, process, and resolve grievances and appeals, including requests for extensions of relevant timeframes, and by which to afford parties proper notice.

317:2-3-4. Member grievances

(a) Filing.

(1) Filing with managed care entity. Except as described in this section, when the member is enrolled in a managed care program, the member initially files a grievance with the managed care entity in which the member is enrolled.

(2) Exception: Filing with OHCA. When the member is enrolled in a managed care program and the grievance deals with direct interaction with OHCA or its employees or officers, the member first files the grievance with OHCA as an administrative appeal pursuant to applicable rules set forth at Oklahoma Administrative Code (OAC) 317:2-1-2 et seq.

(b) Timing. A member may file a grievance, orally or in writing, at any time.

(c) Provider's and authorized representative's right to file a grievance. A provider or an authorized representative may file a grievance on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of a grievance, as applicable.

(d) Clinical expertise in a grievance decision. When a grievance involves clinical issues or is related to a denial of an expedited resolution of an appeal, the decision maker(s) of such a grievance will have clinical expertise as discussed at OAC 317:2-3-6.

(e) Consideration of information in an appeal decision. The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(f) OHCA-established timeframes for grievance decisions. A grievance related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 Code of Federal Regulations (C.F.R.) § 438.408, the standard resolution of a grievance will occur within ninety (90) calendar days after the managed care entity receives the grievance.

(2) OHCA sets the standard resolution of a grievance to occur within sixty (60) calendar days, inclusive of any extensions, after the MCE receives the grievance.

(3) The MCE may extend the timeframe in (f)(2) up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The MCE shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

(4) If the MCE extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay; and

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(5) The MCE will adhere to all OHCA rules related to grievances, including but not limited to:

(A) Observing the timeframe for standard resolution of a grievance;

(B) Sending acknowledgement of receiving the grievance in writing to the member or the member's authorized representative within ten (10) calendar days of receipt; and

(C) Sending written notice conforming with this subchapter to the affected parties within three (3) calendar days following resolution of the grievance.

317:2-3-5. Member appeals

(a) Filing.

(1) Filing with managed care entity. Except as described in this Section, when the member is enrolled in a managed care program, the member initially files an appeal with the managed care entity in which the member is enrolled.

(2) Exception: Filing with OHCA. When the member is enrolled in a managed care program, the member initially files administrative appeals with OHCA and follows the appeals rules set forth at Oklahoma Administrative Code (OAC) 317:2-1-2 et seq. whenever the appeal concerns a decision the Oklahoma Health Care Authority (OHCA) made regarding:

(A) Eligibility for Oklahoma Medicaid;

(B) Eligibility for a managed care program;

(C) Enrollment into Oklahoma Medicaid;

(D) Enrollment, including use of an auto-assignment algorithm, into a managed care entity;

(E) Disenrollment from a managed care entity; or

(F) Any other matter, so long as OHCA made the decision in the matter.

(b) Timing. A member may file an appeal, orally or in writing, at any time. An administrative appeal or State fair hearing request made to OHCA shall conform with the requirements of OAC 317:2-1-2 et seq. in terms of the manner and timing of any such filing.

(c) Levels of appeals. The managed care entity will use only one level of appeals, in accordance with 42 Code of Federal Regulations (C.F.R.) § 438.402.

(d) Provider's and authorized representative's right to file an appeal. A provider or an authorized representative may file an appeal on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of an appeal, as applicable.

(e) Clinical expertise in an appeal decision. When an appeal involves clinical issues or is related to a denial based on lack of medical necessity, the decision maker(s) of such an appeal will have clinical expertise as discussed at OAC 317:2-3-6.

(f) Consideration of information in an appeal decision. The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(g) OHCA-established timeframes for appeals decisions. An appeal related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 C.F.R. § 438.408, the standard resolution of an appeal will occur within thirty (30) calendar days after the managed care entity receives the appeal.

(2) OHCA establishes the following timeframes for appeals:

(A) Standard resolution of an appeal will occur within thirty (30) calendar days, excluding any extensions, after the managed care entity receives the appeal;

(B) Expedited resolution of an appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal;

(C) In exigent circumstances, resolution of a step therapy request appeal will occur within twenty-four (24) clock-hours after the MCE receives the appeal; and

- (D) In all other circumstances, resolution of a step therapy request appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal.
- (3) The MCE may extend the timeframes in (g)(2)(A) or (B) up to fourteen (14) days if:
- (A) The member requests the extension; or
 - (B) The MCE shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.
- (4) If the MCE extends the timeframes not at the request of the member, it must complete all of the following:
- (A) Make reasonable efforts to give the member prompt oral notice of the delay;
 - (B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
 - (C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
- (5) The MCE will adhere to all OHCA policies related to appeals, including but not limited to:
- (A) Observing the timeframes for resolving appeals, including standard resolution, expedited resolution, and resolution of step therapy appeals (in both exigent and other circumstances);
 - (B) Sending acknowledgement of receiving the appeal in writing to the member or the member's authorized representative within five (5) calendar days of receipt;
 - (C) Sending written notice conforming with this subchapter to the affected parties within three (3) calendar days following resolution of the appeal; and
 - (D) Sending documentation, in conformance with OAC 317:2-3-12(d) and any established OHCA forms or processes, to OHCA within fifteen (15) calendar days after a request for State fair hearing.

317:2-3-6. External medical review and clinical expertise

(a) **No external medical review.** The Oklahoma Health Care Authority (OHCA) will not offer an external medical review for the purposes of grievances or appeals.

(b) **Clinical expertise standards.** Individuals making the decision for a grievance or appeal regarding an adverse benefit determination will be unbiased with appropriate clinical expertise in treating the member's condition or disease.

- (1) Medical review staff of the MCE will be licensed or credentialed health care clinicians with relevant clinical training and/or experience.
- (2) All MCEs will use medical review staff for such appeals and shall not use any automated claim review software or other automated functionality for such appeals.
- (3) Bias is deemed to exist if an individual making a decision on a grievance or appeal was involved in, or a subordinate of any individual involved in, any previous level of review or decision regarding the subject matter of the grievance or appeal.
- (4) Clinical expertise is deemed necessary for decisions makers whenever:
 - (A) The denial is based on a lack of medical necessity;
 - (B) The grievance is regarding a denial of an expedited resolution an appeal; and
 - (C) The grievance or appeal involves clinical issues.

317:2-3-7. Obligation to pay costs of services

(a) In accordance with 42 Code of Federal Regulations (C.F.R.) § 438.420(d), the MCE may recover from the member the costs of services provided to the member while an appeal or State fair hearing is pending:

(1) To the extent the services were continued solely due to the requirements set forth in 42 C.F.R. §§ 438.420 or 431.230(b); and

(2) The final resolution of the appeal or State fair hearing upholds the MCE's adverse benefit determination.

(b) If OHCA or the MCE reverses a decision to deny, limit, or delay services and these services were not furnished while the appeal or State fair hearing was pending, the MCE will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(c) If OHCA or the MCE reverses a decision to deny, limit, or delay services and the member received the disputed services while the appeal or State fair hearing was pending, the MCE will pay for these services.

317:2-3-8. Grievances and appeals notice

(a) The MCE will provide timely written notices per OAC 317:2-3-4 and 317:2-3-5.

(b) Each notice will conform to the provisions of 42 Code of Federal Regulations (C.F.R.) § 438.10 related to information provided from an MCE to a member.

(c) At minimum, each notice will:

(1) Be written in a manner and format that may be easily understood and is readily accessible by members;

(2) Use OHCA-developed definitions for terms as those terms are defined in the Model Member Handbook related to the contract;

(3) Use a font size no smaller than twelve-point (12-point);

(4) Be made available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members with disabilities or limited English proficiency; and

(5) Include a large-print tagline, in minimum eighteen-point (18-point) font, and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

(d) Per the delegation choice of 42 C.F.R. § 438.228, OHCA does not delegate responsibility to the MCE for timely notices of action under 42 C.F.R. Part 431, Subpart E.

(1) OHCA retains all responsibility for timely notices of action under 42 C.F.R. Part 431, Subpart E, including:

(A) A termination, suspension of, or reduction in covered benefits or services, when termination, suspension, or reduction is determined by OHCA;

(B) A termination, suspension of, or reduction in Medicaid eligibility, when termination, suspension, or reduction is determined by OHCA; and

(C) An increase in beneficiary liability, including determination that a beneficiary will incur a greater amount of medical expenses in order to establish income eligibility or is subject to an increase in premiums or cost sharing charges, when such increase is determined by OHCA.

(2) The foregoing (d)(1) does not apply to:

(A) Any grievance notice required to be sent by the MCE by contract or 42 C.F.R. § 438.408;

(B) Any adverse benefit determination notice based on the termination, suspension, or reduction of authorized covered services, payment denial, or standard, expedited, or untimely service authorization denial or limitation as required to be sent by the MCE by contract or 42 C.F.R. 438.404;

(C) Any appeal resolution notice required to be sent by the MCE by contract or 42 C.F.R. § 438.404 or 438.408; or

(D) Any other notice required to be sent by the MCE by contract or any state or federal law or regulation.

(3) OHCA's decision not to delegate the notices of action required by 42 C.F.R. Part 431 Subpart E applies to any managed care entity under any managed care contract for professional services unless and until this section is revoked.

(4) The random review system required of a state by 42 C.F.R. § 438.228 does not apply to OHCA, because OHCA has not delegated responsibility for the relevant notices of action.

(5) For any notices of action for which OHCA retains responsibility under this section, OHCA will ensure the notice conforms to federal regulations at 42 C.F.R. Part 431, Subpart E, and any applicable requirements under 42 C.F.R. § 438.228. OHCA will send such notices of action by electronic or postal means at least ten (10) days before the date of action, except as permitted when:

(A) OHCA has factual information confirming the death of a beneficiary;

(B) OHCA receives a clear written statement signed by a member that they no longer wish to receive services or that gives information that requires termination or reduction of services and indicates that the member understands that supplying the information will result in termination or reduction of services;

(C) The member has been admitted to an institution where they are ineligible for further services;

(D) The member's whereabouts are unknown and the post office returns, indicating no forwarding address, OHCA mail sent directly to the member; and

(E) The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

(6) For any notices of action for which OHCA retains responsibility under this Section, OHCA will ensure the notice contains:

(A) A statement of the action OHCA intends to take and the effective date of such action;

(B) A clear statement of the specific reasons supporting the intended action, the specific regulations that support or require the action, and an explanation of the member's rights to request a hearing; and

(C) An explanation of the circumstances under which benefits continue if a hearing is requested.

(7) For any notices of action for which OHCA retains responsibility under this section, OHCA will allow the member a reasonable time, not to exceed ninety (90) days from the date the notice is mailed, to request a State fair hearing.

317:2-3-9. Exhaustion of managed care entity appeals

(a) Deemed exhaustion of MCE appeals. If the MCE fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the member is deemed to have exhausted the MCE's appeal process, and the member or the member's authorized representative may request a State fair hearing.

(b) **Actual exhaustion of MCE appeals.** Except as allowed in (a), a member or the member's authorized representative may request a State fair hearing only after receiving notice from the MCE upholding an adverse benefit determination and only within one hundred twenty (120) days after the date of the notice of appeal resolution.

(c) **Exhaustion of MCE appeals, determination.** OHCA has sole authority to decide whether MCE appeals have been exhausted for any member. Documentation, as submitted to OHCA by the MCE within fifteen (15) calendar days of the request for State fair hearing, will serve as evidence to deemed exhaustion, actual exhaustion, or no exhaustion of the MCE appeals process.

317:2-3-10. Provider complaint system

(a) A participating provider or nonparticipating provider may file a complaint whenever:

(1) The provider is not satisfied with the MCE's policies and procedures; or

(2) The provider is not satisfied with a decision made by the MCE that does not impact the provision of services to members.

(b) The MCE will establish and operate a provider complaint system. Such system will:

(1) Use written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving provider complaints;

(2) Track receipt and resolution of provider complaints, including requests for reconsideration or appeals;

(3) Demonstrate sufficient ability to receive provider complaints by telephone, in writing, or in person;

(4) Designate staff to receive, process, and resolve provider complaints;

(5) Thoroughly investigate each provider complaint;

(6) Ensure an escalation process for provider complaints;

(7) Furnish the provider timely written notification of resolution or results; and

(8) Maintain a tracking system capable of generating reports to OHCA on provider complaint volume and resolution.

(c) The MCE will operate a reconsideration process whereby providers may request the MCE reconsider a decision the MCE has made or intends to make that is adverse to the provider, including, at minimum, reconsiderations of provider audit findings, reconsiderations of provider agreement termination, and reconsiderations of denied claims.

(1) **Request for reconsideration, denied claims.** The MCE will ask that the provider submits a request for reconsideration of a denied claim within six (6) months after the provider receives notice of the denied claim.

(2) **Request for reconsideration, all other reasons.** The MCE will ask that the provider submits a request for reconsideration within fifteen (15) days after the date the provider receives notice of audit findings, termination of provider agreement, or other actions the MCE permits for reconsideration requests.

(3) **Desk review.** The MCE will conduct the reconsideration through a desk review of the request and all related and available documents.

(4) **Reconsideration resolution.** The MCE will resolve all requests for reconsideration within twenty (20) calendar days of the date the MCE receives the request for reconsideration. The MCE will send a reconsideration resolution notice to the provider within three (3) business days of the MCE finalizing the resolution.

(5) **Notice of Reconsideration Resolution.** The MCE will send a reconsideration resolution notice that contains, at a minimum:

- (A) The date of the notice;
- (B) The action the MCE has made or intends to make;
- (C) The reasons for the action;
- (D) The date the action was made or will be made;
- (E) The citation to statute, regulation, policy, or procedure, if any, upon which the action was based;
- (F) An explanation of the provider's ability to submit an appeal request to the MCE within thirty (30) calendar days of the date recorded on the notice;
- (G) The address and contact information for submitting an appeal;
- (H) The procedures by which the provider may request an appeal regarding the MCE's action;
- (I) The specific change in federal or state law, if any, that requires the action;
- (J) The provider's ability to submit a State fair hearing request following completion of the provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a State fair hearing will be granted; and
- (K) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(d) The MCE will operate an appeals process whereby a provider may request an appeal of a reconsideration resolution when the underlying matter is based on the MCE's provider audit findings, for-cause or immediate termination of the provider agreement, or a denied claim.

(1) **Request for appeal.** The MCE will require the provider to submit a request for appeal in writing within thirty (30) calendar days after the provider receives notice reconsideration resolution.

(2) **Panel review.** The MCE will conduct the appeal through a panel review including a hearing and review of the request, all related and available documents, and all documents created for or used in connection with the request for reconsideration.

(A) The panel will consist of three (3) or five (5) reviewers, who are employees or officers of the MCE.

(B) Panel members will not have been directly involved with the reconsideration desk review and will not be a subordinate of someone involved directly with the reconsideration desk review.

(C) The panel review hearing will provide the provider or an authorized representative of the provider with a reasonable opportunity to be heard in person or by telecommunications.

(D) The review panel will accept and document any exhibit offered prior to the hearing or during the hearing, so long as the exhibit directly relates to the matter of the appeal.

(E) When the appeal is based on a claim denied on the basis of medical necessity, the following requirements apply:

(i) Medical review staff of the MCE will be licensed or credentialed health care clinicians with relevant clinical training or experience; and

(ii) All MCEs will use medical review staff for such appeals and will not use any automated claim review software or other automated functionality for such appeals.

(3) **Appeal resolution.** The MCE will resolve all appeals within forty-five (45) calendar days of the date the MCE receives the request for appeal. The MCE will send an appeal resolution notice to the provider within three (3) business days of the MCE finalizing the resolution.

(4) **Notice of Appeal Resolution.** The MCE will send an appeal resolution notice that contains, at a minimum:

(A) The date of the notice;

(B) The date of the appeal resolution; and

(C) For decisions not wholly in the provider's favor:

(i) An explanation of the provider's ability to request a State fair hearing within thirty (30) calendar days of the date recorded on the notice;

(ii) How to request a State fair hearing, including the OHCA address and contact information for submitting a request;

(iii) Details on the right to be represented by counsel at the State fair hearing; and

(iv) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(5) **Documentation.** The MCE will furnish to OHCA documentation including all information specified at OAC 317:2-3-13(c)(2) within fifteen (15) calendar days of a provider's request for a State fair hearing.

317:2-3-11. Recordkeeping

In compliance with 42 C.F.R. § 438.3(h) and (u), the MCE will maintain records of each grievance and appeal for ten (10) years after the later of the final date of the contract period or the date of completion of any MCE audit by the State, the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General, or the Comptroller General. Such records will be part of OHCA's ongoing monitoring and will be used to update and revise OHCA's managed care quality strategy. The record will conform with the content requirements at 42 C.F.R. § 438.416.

317:2-3-12. State fair hearing for members

(a) **Right to State fair hearing.** With regard to grievances or appeals first filed with the MCE, a member may request a State fair hearing under 42 C.F.R. 431 Subpart E only after receiving notice from the MCE upholding an adverse benefit determination. The member will have one-hundred twenty (120) days from the date of the adverse benefit determination notice to request a State fair hearing. Refer to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1).

(b) **MCE policies and procedures.** The MCE will implement established policies and procedures that allow a member described in (a) to initiate a State fair hearing process after having exhausted the MCE's appeals process or after the member is deemed to have exhausted the process due to the MCE's failure to adhere to notice and timing requirements.

(c) **Member's request for a State fair hearing.** The MCE will allow the member to request a State fair hearing either through an established MCE process or through an established OHCA process. Any MCE process will ensure that notice of the request for State fair hearing is communicated in writing to the OHCA contracting officer within twenty-four (24) clock-hours of receiving the request.

(d) **MCE documentation obligation.** The MCE will provide documentation to the member, the member's authorized representative, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The MCE will provide the documentation described in this subsection:

(A) Within twenty-four (24) clock-hours after receiving notification of the request for State fair hearing relating to a step therapy request; or

(B) Within fifteen (15) calendar days after notification of the request for State fair hearing in all other circumstances.

(2) Information. Documentation will include, at minimum, the following information:

(A) The name and address of the member and, if applicable, the member's authorized representative;

(B) A summary statement concerning why the member has filed a request for State fair hearing;

(C) A brief chronological summary of the MCE's action in relationship to the matter underlying the member's request for State fair hearing;

(D) The member's appeal request, along with any supporting documentation, if received by the MCE;

(E) Any applicable correspondence between the MCE and the member, including system notes entered by one or more MCE employees based on one or more telephone conversations with the member;

(F) All exhibits offered at any hearing held with the MCE;

(G) All documents the MCE used to reach its decision;

(H) A statement of the legal basis for the MCE's decision;

(I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;

(J) A copy of the notice which notified the member of the decision in question;

(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and

(L) Any other information requested by the member, the member's authorized representative, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.

(e) MCE staffing. The MCE will maintain a sufficient level of staffing to competently perform the functions, requirements, roles, and duties involved in State fair hearing support, including but not limited to documentation, summarization of the arguments presented, and ensuring timely notice and delivery of documents to all parties.

(f) Performance targets. OHCA may set performance targets related to State fair hearing requests that are resolved upholding the MCE's original determination when and as OHCA deems necessary or appropriate.

(g) Post-transition obligations. After termination or expiration of the managed care contract, the MCE will remain responsible for State fair hearings related to dates of service prior to the contract termination or expiration, including but not limited to the provision of records and representation at State fair hearings.

(h) Cost of services. If the State fair hearing officer reverses the MCE's decision to deny authorization of services and the member received the disputed services while the State fair hearing was pending, the MCE will pay for those disputed services.

317:2-3-13. State fair hearing for providers

(a) Right to State fair hearing. With regard to provider audit findings, for-cause and immediate termination of the provider's agreement, and claims denial, a provider may request a State fair hearing within thirty (30) calendar days of the MCE's notice of appeal resolution when that resolution does not favor the provider.

(b) Information for providers. As a part of the MCE's provider complaint system, the MCE will provide information to providers on how to request a State fair hearing via filing the appropriate form with the OHCA Docket Clerk.

(c) **MCE documentation obligation.** The MCE will provide documentation to the provider, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The MCE will provide the documentation described in this subsection within fifteen (15) calendar days after notification of the request for State fair hearing.

(2) **Information.** Documentation will include, at minimum, the following information:

(A) The name and address of the provider;

(B) A summary statement concerning why the provider has filed a request for State fair hearing;

(C) A brief chronological summary of the MCE's action in relationship to the matter underlying the provider's request for State fair hearing;

(D) The provider's appeal request, along with any supporting documentation, if received by the MCE;

(E) Any applicable correspondence between the MCE and the provider, including system notes entered by one or more MCE employees based on one or more telephone conversations with the provider;

(F) All exhibits offered at any hearing held with the MCE;

(G) All documents the MCE used to reach its decision;

(H) A statement of the legal basis for the MCE's decision;

(I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;

(J) A copy of the notice which notified the provider of the decision in question;

(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and

(L) Any other information requested by the provider, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.

317:2-3-14. Administrative Law Judge (ALJ) jurisdiction

The ALJ has jurisdiction of the following matters:

(1) **Member State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a member's MCE appeal of an adverse benefit determination.

(2) **Provider State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a provider's appeal of audit findings, for-cause or immediate termination of the provider's contract with the MCE, or claims denial.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE**

SUBCHAPTER 7. SOONERCARE

PART 3. ENROLLMENT CRITERIA

317:25-7-12. Enrollment/eligibility requirements

(a) Eligible SoonerCare members mandatorily enrolled in SoonerCare Choice include persons categorically related to AFDC, ~~Pregnancy-related services and Aged, Blind or Disabled;~~ pregnancy-related services; expansion adult; and aged, blind or disabled who are not dually-eligible for SoonerCare and Medicare.

(b) Children in foster care may voluntarily enroll into SoonerCare Choice.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 55. MANAGED CARE

SUBCHAPTER 1. GENERAL PROVISIONS

317:55-1-1. Purpose; use of manuals

The purpose of this Chapter is to provide detailed rules which govern the delivery of health care services provided by managed care organizations or dental benefits managers as required by the "Ensuring Access to Medicaid Act", 2021 Okla. Sess. Law Serv. Ch. 542 (S.B. 131), Title 56 of the Oklahoma Statutes, Sections 4002-4004 and 42 Code of Federal Regulations (C.F.R.), Part 438. The Oklahoma Health Care Authority may also develop manuals and medical guidelines that formalize terms, conditions, and applicable policy of awarded contracts.

317:55-1-2. Monitoring system for all managed care programs

In accordance with 42 C.F.R. § 438.66, the Oklahoma Health Care Authority will monitor each managed care organization or dental benefits manager to assess its ability and capacity to comply with program- and contract-specific requirements and to assess its ability to perform satisfactorily in all major operational areas.

317:55-1-3. Definitions

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

"**1115 waiver**" means the demonstration waiver, 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 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.

"**Accountable care organization**" or "**ACO**" means a group of clinicians, hospitals, or other health care providers who come together voluntarily to give coordinated high-quality care to a designated group of patients.

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

"**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.

"**Adverse determination**" means a determination by a health carrier, including an managed care organization (MCO) or dental benefits manager (DBM), or its designee that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for services is therefore denied, reduced or terminated.

"**Alternative benefit plan**" means the benefit package delivered to expansion adults which is developed by OHCA and approved by the Centers for Medicare and Medicaid Services (CMS) in accordance with the requirements of Subpart C of 42 C.F.R. Part 440.

"**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 MCO or DBM of an adverse benefit determination.

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

"Capitation payment" means a payment, based on an actuarially sound capitation rate for the provision of Oklahoma Medicaid State Plan services under a managed care contract, that OHCA makes periodically to the MCO or DBM behalf of each enrollee enrolled in that MCO or DBM, regardless of whether the enrollee actually receives services during the period covered by the payment.

"Capitation rate" means the actuarially sound per-enrollee, per-month amount, including any adjustments, that OHCA agrees to pay an MCO or DBM for the provision of State Plan services.

"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.

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

"Choice counseling" means the provision of information and services designed to assist eligibles in making enrollment decisions related to the managed care program. Choice counseling includes answering questions and identifying factors to consider when choosing among MCOs or DBMs, as well as when choosing a patient-centered medical home provider or dental home provider. Choice counseling does not include making recommendations for or against enrollment into a specific MCO or DBM.

"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 MCO 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.

"Claims denial error rate" means the rate of claims denials that are overturned on appeal.

"Clean claim" means a properly completed billing form with coding based on Current Procedural Terminology (CPT), 4th Edition or a more recent edition, the Tenth Revision of the International Classification of Diseases 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.

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

"Contract" means the risk contract or the written and executed agreement between OHCA and a health plan or managed care organization or dental benefit manager for health plan or managed care services and includes the solicitation, the bid, the contract addenda, appendices, attachments, and amendments, and any documents incorporated into the contract by reference or otherwise, as well as any document or information subject to the rules on legally binding procurement in Chapter 10 of these rules.

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

"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.

"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 a health plan under contract with the OHCA to manage and deliver dental benefits and services to enrollees and designated as a pre-paid ambulatory health plan (PAHP) under 42 C.F.R. Part 438.

"Dental home" or "DH" means the care coordinated delivery system as defined within the contract between OHCA and a DBM.

"Disenrollment" means OHCA's removal of an enrollee from participation in a specific MCO or DBM or from participation in the managed care program.

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

"Eligible" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma and is eligible for participation in the managed care program but who is not yet enrolled in an MCO or DBM.

"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.

"Enrollee" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma, who has been deemed eligible for enrollment in a managed care program, and who is currently enrolled in a managed care program.

"Enrollee handbook" means a guidebook prepared as a model by OHCA and modified and distributed by the MCO or DBM to its enrollees. The enrollee handbook is designed to help the enrollee understand the MCO or DBM, the managed care program, and the rights and responsibilities that come with enrollment in the program.

"Enrollment" means the OHCA process by which an eligible becomes an enrollee with an MCO or DBM.

"Enrollment activities" means activities that OHCA performs or conducts related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling eligibles into any MCO or DBM.

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

"Essential hospital services" means tertiary care hospital services to which the MCO must provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

"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.

"Former foster 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 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.

"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 to make an authorization decision when proposed by the MCO or DBM.

"**Grievance and appeal system**" means the processes the MCO 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 Medicaid State Plan services provided, according to contract, by the MCO 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.

"**Implementation**" means the process by which OHCA and the MCO 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.

"**Implementation period**" means the period of time, as defined in contract, during which implementation occurs.

"**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 MCO or DBM during the initial enrollment period.

"**Initial enrollment period**" means the first period of time, as defined in contract, prior to or immediately following managed care program or contract implementation, when eligibles can first enroll in an MCO or DBM for the managed care program.

"**Managed care organization**" or "**MCO**" means a health plan designated as a managed care organization pursuant to 42 C.F.R. 438.2 and under contract with OHCA to participate in the managed care program and to deliver health care services to enrollees.

"**Managed care program**" or "**managed care**" or "**MCP**" means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"**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.

"**Material change**" means, but not limited to, any change in the overall business operations such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of enrollees or participating providers of the MCO or DBM.

"**Medical necessity**" 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 MCOs, 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-participating provider**" means a physician or other provider who has not contracted with or is not employed by the MCO or DBM to deliver services under the managed care program.

"**Non-urgent sick visit**" means medical care given for an acute onset of symptoms which is not emergent or urgent in nature 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.

"**Open enrollment**" means an eligible's selection of and enrollment in an MCO or DBM during the open enrollment period.

"**Open enrollment period**" means the annual period of time, as defined by contract, when managed care enrollees and eligibles can enroll in and select an MCO or DBM for the managed care program.

"**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 an MCO or DBM to provide health care services to enrollees under the capitated managed care delivery model of the managed care program.

"**Patient-centered medical home**" or "**PCMH**" means, in this chapter, the care coordinated delivery system as defined within the contract between OHCA and an MCO.

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

"**Presumptive eligibility**" means limited period of managed care program 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 hospital, on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for managed care program services.

"**Primary care dentist**" or "**PCD**" means a provider under contract with a DBM to provide primary health care services, as contracted, and case management, including all medically necessary referrals for specialty services and prior authorizations. In these rules, "dental home provider" or "DH provider" bears the same meaning as "primary care dentist" or "PCD".

"**Primary care provider**" or "**PCP**" means a provider under contract with an MCO to provide primary health care services, as contracted, and case management, including securing all medically necessary referrals for specialty services and prior authorizations. In these rules, "patient-centered medical home provider" or "PCMH provider" bears the same meaning as "primary care provider" or "PCP".

"**Prior authorization**" or "**PA**" means a requirement that an enrollee, through the enrollee's provider, obtain the MCO's 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.

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

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

"**Risk contract**" means a contract between OHCA and an MCO, 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.

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

"**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.

"**Specialty Children's Plan**" means the single statewide managed care plan, as contracted with a single MCO, that will coordinate and deliver health care services, as defined by contract, in a highly coordinated manner to the specialty population. The specialty population includes Medicaid eligibles who are FFC, select juvenile justice involved Office of Juvenile Affairs (OJA), in foster care (FC), children with an open prevention services case (PSC) through case workers or receiving adoption assistance (AA).

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

"**Steady state enrollment**" means the period of time, as defined by contract, when an individual, who first became an eligible during steady state operations or who became eligible again during steady state operations after more than two (2) months lapse of eligibility, can first enroll in and select an MCO or DBM for the managed care program.

"**Steady state operations**" or "**steady state**" means the period of time, as defined by contract, after initial implementation and prior to contract termination, during which all managed care program elements are expected to be operational.

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

"**Value-added benefit**" means any benefit or service offered by an MCO 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 MCO or DBM and OHCA.

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

"**Value-based purchasing**" means the provisions of a contract for managed care services when those provisions intentionally align OHCA payments to the MCO or DBM under contract with quality measures or other performance factors OHCA may apply to the MCO or DBM.

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

PART 1. ELIGIBILITY

317:55-3-1. Mandatory populations

(a) Mandatory MCO enrollment. Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with an MCO:

- (1) Expansion adults;
- (2) Parents and caretaker relatives;
- (3) Pregnant women;
- (4) Deemed newborns;
- (5) Children; and
- (6) All other populations requiring mandatory coverage pursuant to in 42 C.F.R. Part 435,

Subpart B (§§ 435.100 435.172), unless otherwise covered by SoonerCare.

(b) Mandatory Specialty Children's Plan enrollment. Per 56 O.S. § 4002.3, eligibles in the following categories, upon entering custody of the State, will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan:

- (1) Foster children (FC); and
- (2) Certain children in the custody of OJA.

(c) Mandatory Specialty Children's Plan enrollment, opt out. Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan, if they do not select a different MCO during initial enrollment, open enrollment, or steady state enrollment:

- (1) Former foster care (FFC); and
- (2) Children receiving adoption assistance (AA).

(d) Mandatory DBM enrollment. Per 56 O.S. § 4002.3, the following eligibles will be mandatorily enrolled in the MCP and with a DBM:

- (1) Expansion adults;
- (2) Parents and caretaker relatives;
- (3) Pregnant women;
- (4) Deemed newborns;
- (5) Former foster children;
- (6) Certain children in the custody of OJA;
- (7) Foster care children;
- (8) Children receiving adoption assistance; and
- (9) Children.

317:55-3-2. Excluded populations

(a) Per 56 O.S. § 4002.3, individuals in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more MCOs:

- (1) Dual eligible individuals;
- (2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
- (3) Persons with a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any MCO for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from an MCO, such excepted enrollees will receive a facility's pre-admission screening and resident review (PASRR) process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from their MCO;
- (4) Individuals during a period of presumptive eligibility;
- (5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
- (6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
- (7) Individuals enrolled in a 1915(c) waiver;
- (8) Undocumented persons eligible for emergency services only in accordance with 42 C.F.R. § 435.139;
- (9) Insure Oklahoma employee sponsored insurance (ESI) dependent children in accordance

with the Oklahoma Title XXI State Plan;

(10) Coverage of pregnancy-related services under Title XXI for the benefit of unborn children (Soon- to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and

(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

(b) Per 56 O.S. § 4002.3, eligibles in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more DBMs:

(1) Dual eligible individuals;

(2) Individuals enrolled in the Medicare Savings Program, including QMB, SLMB, QDW and QI;

(3) Persons with a nursing facility or ICF-IID level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any DBM for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from a DBM, such excepted enrollees will receive a facility's PASRR process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from the DBM.

(4) Individuals during a period of presumptive eligibility;

(5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;

(6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;

(7) Individuals enrolled in a §1915(c) waiver;

(8) Undocumented persons eligible only for emergency services in accordance with 42 C.F.R. § 435.139;

(9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;

(10) Coverage of Pregnancy-related services under Title XXI for the benefit of unborn children (Soon-to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and

(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

317:55-3-3. Voluntary enrollment and disenrollment

(a) Per 56 O.S. § 4002.3, AI/AN populations that are eligible for SoonerCare will have the option to:

(1) Voluntarily enroll in the MCP through an opt-in process;

(2) Enroll in an MCO or DBM at each open enrollment period, regardless of initial selection or past disenrollment from the MCP;

(3) Receive services from an IHCP;

(4) Choose the IHCP as the enrollee's PCMH provider or DH provider, if the provider has the capacity to provide such services;

(5) Obtain services covered under the contract from out-of-network IHCPs when the enrollee is otherwise eligible to receive the IHCP's services;

(6) Self-refer for services provided by IHCPs to AI/AN enrollees;

(7) Obtain services covered under the contract from out-of-network IHCPs when the AI/AN enrollee is otherwise eligible to receive the IHCP's services; and

(8) Disenroll from any MCO or DBM at any time without cause.

(b) Children receiving prevention services from child welfare services have the option to enroll in the MCO contract to provide health care services under the Specialty Children's Plan.

PART 3. SCOPE AND ADMINISTRATION

317:55-3-10. Grievances and appeals

(a) Filing. Grievances and appeals are to be initially filed with each enrollee's MCO or DBM. Grievances may be filed with the enrollee's MCO or DBM at any time, either orally or in writing. A provider or an authorized representative may file an appeal, grievance, or request for a State fair hearing on behalf of an enrollee, provided that the provider or authorized representative has obtained the enrollee's written consent.

(b) Levels of appeal. Pursuant to 42 C.F.R. § 438.402, MCOs and DBMs will only have one (1) level of appeal. Enrollees and providers may file an appeal to OHCA seeking the review of a final adverse benefit determination rendered by an MCO or DBM.

(c) Governing rules. The provisions at OAC 317:2-1-1 et seq. will govern any enrollee or provider right to file a grievance, complaint, appeal or request for a State fair hearing pursuant to 56 O.S. § 4002-4004, 42 C.F.R. Parts 431 or 438, or the managed care contract.

317:55-3-11. Intermediate sanctions

(a) Intermediate sanctions obligation. OHCA will establish intermediate sanctions that it may impose on an MCO if OHCA makes any of the determinations specified in 42 C.F.R. § 438.700(b)—
(d).

(b) Adoption of intermediate sanctions. OHCA adopts the intermediate sanctions as provided at 42 C.F.R. § 438.702.

(c) Imposition of sanctions. If OHCA makes a determination per 42 C.F.R. §§ 438.700 or 438.706 and thereby imposes intermediate sanctions as listed at 42 C.F.R. §§ 438.702 or 438.706, OHCA will consider the totality of and follow all relevant regulations at 42 C.F.R. Part 438, Subpart I.

(d) Required imposition of temporary management. In accordance with 42 C.F.R. § 438.706(b), OHCA will impose the intermediate sanction of temporary management, regardless of any other sanction that may be imposed, if OHCA finds that an MCO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 C.F.R. Part 438. In this situation, OHCA will also grant enrollees the right to terminate enrollment without cause, as described in 42 C.F.R. § 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment. Notwithstanding any other Section of these rules, OHCA will not delay imposition of temporary management to provide a hearing before imposing this sanction. OHCA will continue this sanction until the MCO can ensure that the sanctioned behavior will not recur.

(e) Retained authority. OHCA retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in 42 C.F.R. Part 438, Subpart I, prevents OHCA from exercising that authority.

(f) Notice. Before imposing an intermediate sanction, OHCA will give the affected MCO timely written notice that explains the basis and nature of the sanction and any other appeal rights that OHCA elects to provide.

(g) Right to request fair hearing. Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a sanction other than optional or required temporary management, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO must file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are

met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.

(3) At the ALJ's discretion, the ALJ will:

(A) Establish a scheduling order;

(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(C) Rule on all interlocutory motions;

(D) Require briefing of any or all issues;

(E) Conduct hearings in a forum and manner as determined by the ALJ;

(F) Rule on the admissibility of all evidence;

(G) Question witnesses;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing and manner in which it will be conducted;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Make proposed findings of facts and conclusions of law; and

(P) Sustain or deny OHCA's imposition of the sanction(s).

317:55-3-12. Non-compliance damages and remedies

If OHCA finds an MCO or DBM to be in violation of the provisions of 56 O.S. §§ 4002-4004, rules promulgated thereto, or the terms and conditions of the contract, OHCA may enforce any damages or remedies for non-compliance as required by CMS, as provided for in the contract, or as permitted by State or Federal law.

317:55-3-13. Termination of managed care contract

(a) **Termination of an MCO, permitted by 42 C.F.R. § 438.708.** Members impacted by the contract termination of an MCO will be enrolled with a different MCO or be provided Medicaid benefits through options as prescribed in the Oklahoma Medicaid State Plan. OHCA may terminate a contract with an MCO if OHCA determines that the MCO:

(1) Failed to carry out the substantive terms of the contract; or

(2) Failed to meet applicable requirements of sections 1903(m), 1905(t), or 1932 of the Act.

(b) **Termination permitted by contract, MCO or DBM.** Grounds for termination include:

(1) **Mutual consent.** OHCA and the MCO or DBM may terminate the contract by a mutually written agreement. The MCO or DBM does not have the right to appeal the termination. Enrollees impacted by the contract termination will be enrolled with a different MCO or DBM

of their choosing or, if no choice is made, a default MCO or DBM.

(2) **Termination for convenience.** OHCA may terminate a contract for convenience, in whole or part, with a sixty (60) day written notice to the MCO or DBM if the State determines that termination is in the State's best interest. Any partial termination of the contract will not be construed as a waiver of, and will not affect, the rights and obligations of any party regarding portions of the contract that remain in effect. Upon receipt of notice of such termination, the MCO or DBM will immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice.

(3) **Termination for unavailability of funds.** OHCA may terminate a contract for lack of the availability of funds with written notice to the managed care. OHCA will give written notice to the MCO or DBM, effective the close of business on the day specified. OHCA is the final authority on the availability of funds, and the MCO or DBM does not have the right to appeal this termination.

(4) **Termination for lack of authority.** In the event that the State is determined, in whole or part, to lack Federal or State approval or authority to contract with an MCO or DBM, OHCA may terminate the contract immediately, effective on the close of business on the day specified. The MCO or DBM does not have the right to appeal this termination.

(5) **Termination for default.** OHCA may terminate the contract, in whole or in part, whenever the MCO has failed to carry out the terms of the contract or meet the applicable readiness requirements of §§ 1932, 1903(m) or 1905(t) of the Act.

(6) **Termination for financial instability.** In the event that OHCA, in its sole discretion, deems an MCO or DBM to be financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this contract, or to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate the contract effective on the close of business on the date specified. In the event OHCA elects to terminate the contract under this provision, the MCO or DBM will be notified in writing specifying the date of termination. In the event of the filing of a petition in bankruptcy court by or against a principal subcontractor, the MCO or DBM will immediately advise OHCA. The MCO or DBM will ensure that all tasks related to the subcontract are performed in accordance with the terms of the contract.

(7) **Termination for debarment.** Section 1932(d)(1) of the Act prohibits affiliations with individuals debarred by federal agencies. The MCO will not knowingly have an individual or affiliate, as defined in Section 1932(d)(1)(C), who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(c) **Notice and pre-termination hearing.** Prior to terminating an MCO's contract for default, financial instability, or debarment, OHCA will provide the MCO a pre-termination hearing. OHCA will:

(1) Give the MCO written notice of the intent to terminate, the reason for termination, and the time and place of the hearing. The notice will detail how the MCO has failed to carry out the terms of the contract and/or failed to comply with the requirements of 1932, 1903(m) and 1905(t) of the Act. A time period will be provided, if applicable, in which the MCO is allowed to cure the default prior to the pre-termination hearing. If the MCO cures the default within the specified timeframe, no further action is required;

(2) After the hearing, the MCO will receive written notice of the decision affirming or reversing

the proposed termination of the contract. In the event the decision is affirmed the notice is to include the effective date of the termination; and

(3) Upon affirmation of a decision, OHCA will give enrollees of the MCO written notice, comporting with the content requirements of 42 C.F.R § 438.10, of the termination and information identifying options for receiving Medicaid services following the effective date of termination. This notice will be provided within five (5) business days of the affirming decision.

(d) **Hearing timing.** Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a termination, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO will file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.

(3) At the ALJ's discretion, the ALJ will:

(A) Establish a scheduling order;

(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(C) Rule on all interlocutory motions;

(D) Require briefing of any or all issues;

(E) Conduct hearings in a forum and manner as determined by the ALJ;

(F) Rule on the admissibility of all evidence;

(G) Question witnesses;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing and manner in which it will be conducted;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Make proposed findings of facts and conclusions of law; and

(P) Sustain or deny OHCA's imposition of the termination(s).

317:55-3-14. Record retention

In addition to the requirements found at OAC 317:30-3-15 and 317:30-5-70.2, the MCO or DBM and its affiliates, subcontractors, and employees must retain records in compliance with the

provisions and spirit of 42 C.F.R. §§ 438.3(h) and (u), to the extent applicable.

PART 5. REQUIRED FEDERAL AUTHORIZATIONS

317:55-3-20. Authorizations

Prior to the implementation of any MCP authorized under 42 C.F.R. Part 438, OHCA will receive the following authorizations:

- (1) Federal authority through a State Plan Amendment or waiver of the Act;
- (2) CMS approval of each contract in relation to the MCP;
- (3) CMS approval of all contract rates authorized under the MCP; and
- (4) CMS approval of direct payment arrangements authorized under the MCP.

317:55-3-21. Timing

OHCA may only execute transition to a managed care delivery system ninety (90) days after CMS has approved all contracts entered into between OHCA and all MCOs or DBMs following OHCA's submission of readiness review results to CMS, pursuant to 42 C.F.R. § 438.66.

SUBCHAPTER 5. REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND DENTAL BENEFITS MANAGERS

PART 1. ACCREDITATION AND READINESS

317:55-5-1. MCO or DBM accreditation

All MCOs and DBMs will be accredited in accordance with 45 C.F.R. § 165.275 by an accrediting entity recognized by the United States Department of Health and Human Services.

317:55-5-2. MCO or DBM readiness

(a) According to 42 C.F.R. § 438.66, during implementation and prior to enrollment effective dates, the MCO or DBM will participate in a readiness review process. To be deemed eligible to effect enrollments, the MCO or DBM will complete all readiness review activities to the satisfaction of OHCA and CMS. The readiness reviews will be conducted through one (1) or more desk reviews and one or more on-site reviews. The MCO or DBM must satisfactorily demonstrate readiness for MCP operations, including but not limited to focus areas identified at 42 C.F.R. § 438.66(b). At any stage(s) of the readiness review process, OHCA may but is not required to provide an MCO or DBM with notice(s) of deficiency and reasonable opportunity(ies) to cure the deficiency. As between the parties to the managed care contract, OHCA has sole authority to determine the readiness of any MCO or DBM.

(b) As a part of any readiness review, OHCA will ensure the MCO or DBM meets the requirements at 56 O.S. § 4002.10.

PART 3. PROVIDER REQUIREMENTS

317:55-5-10. Provider contracts and credentialing standards

(a) All MCOs and DBMs will formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by OHCA in accordance with 42 C.F.R. § 438.214 and in coordination with MCOs and DBMs.

(b) All MCOs and DBMs will contract to the extent possible and practicable with all essential

community providers who receive directed payments in accordance with 42 C.F.R. Part 438 and any other providers as specified by OHCA through contract.

(c) Every MCO and DBM will contract with every participating provider through a written provider agreement that:

(1) Identifies the contractual obligations between the MCO or DBM and the participating provider; and

(2) Incorporates any provision required by the contract between OHCA and the MCO or DBM for inclusion in the provider agreement.

(d) An MCO or DBM or any subcontractor thereof will not enforce with any provider a policy or contract term that requires the provider to contract for all products currently offered or that may be offered in the future by the MCO, DBM, or subcontractor.

317:55-5-11. Network adequacy standards

In accordance with 42 C.F.R. § 438.604, the MCO or DBM will submit documentation for which OHCA will base its certification to CMS that the MCO or DBM has complied with requirements for availability and accessibility of services, including health professional shortage areas and adequacy of the MCO's or DBM's network, as set forth in 42 C.F.R. §§ 438.206, 438.14 and 438.68.

317:55-5-12. Prior authorization requirements, generally

The OHCA will establish prior authorization requirements that are consistent with 56 O.S. §§ 4002-4004. MCOs and DBMs may establish prior authorization of benefits to the extent these are consistent with OHCA's policies and rules. The MCO or DBM may propose to impose additional prior authorization requirements, subject to OHCA's review and approval, except for those benefits identified in the Oklahoma Medicaid State Plan, rules, or practices as exempt from prior authorization. The MCO or DBM may be less restrictive on the requirements of a prior authorization than OHCA but may not impose greater restrictions.

317:55-5-13. Notification of material change

An MCO or DBM will promptly, within one (1) business day, notify OHCA of all changes materially affecting the delivery of care or the administration of the MCP.

317:55-5-14. Patient data

An MCO or DBM will provide patient data to a provider upon request to the extent allowed under federal or State laws, rules, or regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996.

PART 5. FINANCE

317:55-5-20. Capitation rates

OHCA will contract with an actuary, as defined at 42 C.F.R. § 438.2, to establish actuarially sound capitation rates, as described at 42 C.F.R. §§ 438.3(c), 438.4, and 438.5, for OHCA to pay to MCOs and DBMs.

317:55-5-21. Medical loss ratio

An MCO or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. § 438.8.

317:55-5-22. Value-based purchasing

In any contract for managed care services, OHCA may include provisions in which payments OHCA makes to an MCO or DBM are based in whole or in part on quality measures and/or any other performance metric as defined in the contract.

317:55-5-23. Special contract provisions related to payment

(a) **Federal regulation.** Any special contract provision related to payment, as described at 42 C.F.R. § 438.6, will meet all related standards within the federal regulation.

(b) Provider payments.

(1) OHCA will establish minimum rates of reimbursement paid by MCOs and DBPs to providers who choose not to enter into value-based payment arrangements for health care items and services furnished by such providers to enrollees.

(A) For participating providers, the reimbursement rate until July 1, 2026, will be equal to or greater than one hundred percent (100%) of the reimbursement rate for the applicable item or service per the applicable OHCA fee schedule.

(B) For non-participating providers and subject to CMS approval as a directed payment or otherwise, the reimbursement rate, until July 1, 2026, will be equal to or greater than ninety percent (90%) of the reimbursement rate for the applicable item or service provided by a non-participating provider per the applicable OHCA fee schedule as of January 1, 2021.

(2) Notwithstanding any other provision of this section, OHCA will comply with payment methodologies required by federal law or regulation for specific types of providers including, but not limited to, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), pharmacies, Indian Health Care Providers (IHCPs), and emergency services.

(c) **Optional value-based payments.** The MCO or DBM will offer optional value-based payment arrangements to all providers. Reimbursement amounts to providers in value-based payment arrangements align with the quality measures OHCA applies to MCOs or DBMs, respectively.

317:55-5-24. Hospital readmission damages

The OHCA will establish a hospital readmission damage program to reduce potentially preventable readmissions. The program will use a nationally recognized tool to establish a base measurement year and a performance year and will provide for risk-adjustment based on the population of the state Medicaid program covered by the MCOs or DBMs. The program will be fully described in the managed care contract so that the program will be founded on contract-current tools, populations, and other factors.

317:55-5-25. Claims processing and methodology; post payment audits

(a) **Claims payment systems.** The MCO or DBM will maintain a claims payment system capable of processing and adjudicating claims for payment in an accurate and timely manner and in full compliance with all State and Federal laws.

(b) **Claim filing.** A claim that is filed by a provider within six (6) months of the date the item or service was furnished will be considered timely, per Oklahoma Administrative Code (OAC) 317:30-3-11.

(c) **Clean claims.** The MCO or DBM will process a clean claim within the time frame outlined in 36 O.S. § 1219.

(1) The MCO or DBM will ensure that at least ninety percent (90%) of clean claims received from all providers are paid within fourteen (14) days of receipt.

(2) A clean claim that is not processed within the time frame will bear simple interest at the monthly rate of one and one-half percent (1.5%), which is payable to the provider.

(d) **Additional documentation.** After a claim has been paid but not prior to payment, the MCO or DBM may request medical records, if additional documentation is needed to review the claim for medical necessity.

(e) **Claim denials.**

(1) A claim denial will include the following information:

(A) Detailed explanation of the basis for the denial; and

(B) Detailed description of the additional information necessary to substantiate the claim.

(2) The MCO or DBM will establish a process for all claim denials by which the provider may identify and provide additional information to substantiate the claim.

(3) A provider will have six (6) months from the receipt of a claim denial to file an appeal per OAC 317:2-3-10.

(f) **Post payment audits.**

(1) In accordance with OAC 317:30-5-70.2, the MCO or DBM will comply with the post payment audit process established by OHCA.

(2) The MCO or DBM will adhere to limits set forth by OHCA regarding the percentage of claims that can be subjected to post payment audits.

(3) An MCO or DBM who has a claims denial error rate of greater than five percent (5%) will be subject to damages as set forth by OHCA in the managed care contract.

PART 7. THE MANAGED CARE QUALITY ADVISORY COMMITTEE

317:55-5-30. Managed care quality advisory committee

(a) The Chief Executive Officer (CEO) of OHCA will establish and appoint members to the MC Quality Advisory Committee (Committee). Committee members serve without compensation and at the pleasure of the CEO. The Committee will consist of:

(1) Participating providers as a majority of the Committee members;

(2) Representatives of hospitals and health systems;

(3) Members of the health care community; and

(4) Members of the academic community with an expertise in health care or other applicable field.

(b) The primary power and duty of the Committee is set forth at 56 O.S. § 4002.13.

(c) Committee meetings will be subject to the Oklahoma Open Meeting Act.

(d) The Committee will select from among its membership a chair and vice chair.

(e) The Committee may meet as often as may be required in order to perform the duties imposed on it.

(f) A quorum of the Committee will be required to approve any final action of the Committee. A majority of the members of the Committee will constitute a quorum.

317:55-5-31. Quality scorecard

(a) Within one (1) year of beginning steady state operations of any MCP, OHCA will create a quality scorecard, in accordance with 56 O.S. § 4002.11, that compares MCOs to one another and DBMs to one another.

(b) OHCA will provide the most recent quarterly scorecard for initial enrollees during choice counseling.

- (c) OHCA will provide the most recent quarterly scorecard to all enrollees at the beginning of each open enrollment period.
- (d) OHCA will publish each quarterly scorecard on its website.

PART 9. ACCOUNTABLE CARE ORGANIZATIONS

317:55-5-40. Accountable care organization, no prohibition

OHCA will not contract with or otherwise prohibit an MCO or DBM from contracting with a statewide or regional ACO to implement the capitated managed care delivery model of the State Medicaid program.

317:55-5-41. Accountable care organization, duties

- (a) Any MCO or DBM that contracts with an ACO will retain full responsibility as to all terms of the MCO's or DBM's managed care contract with OHCA.
- (b) The MCO or DBM will track and report quality metrics of any contracted ACO in accordance with the terms of the MCO's or DBM's managed care contract with OHCA.
- (c) The MCO or DBM will timely and accurately collect and analyze data related to patient utilization and costs. All such data and analysis will be shared with OHCA.
- (d) The MCO or DBM in coordination with the ACO must use collected data to improve quality and target patients for care management interventions and program.

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

**SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH
CHILDREN**

**PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH
BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN**

317:35-6-38. Hospital ~~Presumptive Eligibility~~ presumptive eligibility (HPE)

(a) **General.** ~~Hospital Presumptive Eligibility (HPE)~~ HPE is a limited period of SoonerCare eligibility for individuals who are categorically related to certain ~~MAGI~~ Modified Adjusted Gross Income (MAGI) eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital ~~(see OAC 317:35-6-38(a)(2)(A) through (L)) for the conditions of a qualified hospital~~ [see OAC 317:35-6-38(a)(2)(A) through (L) for the conditions of a qualified hospital], on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for SoonerCare services. The rules in this ~~section~~ Section apply only to those individuals applying for, or qualified hospitals determining eligibility under, the HPE program.

(1) **Individuals eligible to participate in the HPE program.** To be eligible to participate in the HPE program, an individual must be categorically related to a MAGI eligibility group (see OAC 317:35-5-2 for categorical relationship criteria) and also meet the income standard and non-medical eligibility specified in this ~~section~~ Section.

(A) **~~MAGI Eligibility Groups~~ eligibility groups.** The following MAGI eligibility groups are eligible to have a presumptive eligibility (PE) determination made by a qualified hospital participating in the HPE program:

- (i) ~~children~~ Children;
- (ii) ~~pregnant~~ Pregnant women;
- (iii) ~~parents and caretaker relatives~~ Parent/caretaker relatives;
- (iv) Expansion adults;
- ~~(iv)~~ (v) former Former foster care children;
- ~~(v)~~ (vi) Breast and Cervical Cancer Treatment (BCC) treatment program; and
- ~~(vi)~~ (vii) SoonerPlan Family planning family planning program.

(B) **Income standard.** The income that is counted in determining PE for an individual is that individual's household income. The income limit for the MAGI eligibility groups covered under the HPE program is the same as defined in OAC 317:35-6-39(b)(8) and is listed on the HPE application. The calculation of countable household income for an individual covered under the HPE program is the same as OAC 317:35-6-39, except that, in determining the individual's household composition, only the MAGI household composition non-filer rules listed under OAC 317:35-6-43 apply for all individuals applying for the HPE program regardless of whether or not the individual is a tax filer, plans on filing taxes, or is a tax dependent.

(C) **Non-medical eligibility requirements.** Individuals covered under the HPE program must also meet the non-medical eligibility requirements described in OAC 317:35-5-25.

(D) **Pregnant women covered under the HPE program.** Coverage for pregnant women who are covered under the HPE program is limited to ambulatory prenatal care only, and

the number of PE periods that may be authorized for pregnant women is one (1) per pregnancy. Pregnant women who may be covered for the benefit of the unborn child(ren) under Title XXI are not eligible for the HPE program.

(E) **Other individuals covered under the HPE program.** Coverage for other individuals listed under OAC 317:35-6-38(a)(1)(A)(i) through (vi) who are covered under the HPE program, except for pregnant women, is the same as covered under the State Plan. The number of PE periods that may be authorized is one (1) period every ~~365~~three hundred sixty-five (365) days beginning on the date the individual is enrolled in HPE.

(2) **Qualified hospital.** The decision that a hospital is qualified to make PE determinations is made by the ~~OHCA~~Oklahoma Health Care Authority. In order to participate in the HPE program and make PE determinations, a qualified hospital must:

(A) Meet all the conditions of an eligible provider under OAC 317:30-5-40;

(B) Elect to participate in the HPE program by:

(i) Completing and submitting a HPE Statement of Intent and Memorandum of Understanding to the OHCA and agreeing to all the terms and conditions of the HPE program;

(ii) Amending its current contract with the OHCA to include participation in the HPE program;

(C) Assign and designate a hospital employee to serve as the HPE program administrator and point of contact;

(D) Assign and designate hospital employees to make PE determinations. The term ~~Authorized Hospital Employee(s) (AHE)~~authorized hospital employee(s) (AHE) means all individuals making PE determinations on behalf of a hospital participating in the HPE program. The AHE must meet the following conditions:

(i) Be an employee of the hospital (i.e. the AHE may not be a third party contractor);

(ii) Attend, complete, and pass the HPE program training course provided and assessed by the OHCA;

(iii) The AHE certificate of HPE course completion must be kept in the worker's file at the hospital and must be made available to the OHCA upon request;

(iv) Follow state and federal privacy and security requirements regarding patient confidentiality;

(v) Agree to abide by all the rules and guidelines of the HPE program established by the OHCA under this ~~section~~Section.

(E) Notify the OHCA of any changes in the AHE's employment status or in the designation of that individual as the hospital's AHE;

(F) Abide by the rules and regulations of the Uniform Electronic Transaction Act as outlined in OAC 317:30-3-4.1;

(G) Keep internal records of all individuals for whom a PE determination was made and make those records available to the OHCA upon request;

(H) Agree to submit all completed HPE applications and PE determinations to the OHCA within ~~5~~five (5) days of the PE determination;

(I) Notify the applicant in writing, or in cases where the HPE application was made on behalf of a child, notify the child's parent or caretaker of the PE determination outcome and provide and explain to eligible members the "HPE Program Policy and Enrollment" form;

(J) Assist HPE applicants with the completion of a full SoonerCare application within ~~15~~fifteen (15) days of the HPE application submission to the OHCA;

(K) Agree to adhere to the processes and procedures established by the OHCA regarding the operation and oversight of the HPE program; and

(L) Cooperate with the OHCA regarding audit and quality control reviews on PE determinations the hospital makes. The agency may terminate the HPE agreement with the hospital if the hospital does not meet the standards and quality requirements set by the OHCA.

(3) **Limited hospital PE determinations.** The agency limits the PE determinations that a hospital may make to only those eligibility groups described in OAC 317:35-6-38(a)(1)(A) using the MAGI methodology rules established for the HPE program. Additionally, PE determinations made for individuals categorically related to the Breast and Cervical Cancer ~~Treatment~~(BCCEDP) treatment program are limited to qualified hospitals that are also qualified entities through the ~~NBCCEDP~~National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

(b) **General provisions of the HPE program.** The agency provides SoonerCare coverage to eligible individuals covered during a period of PE.

(1) **PE period.** The PE period begins on the date a qualified hospital determines an individual to be eligible under the HPE program. A qualified hospital has ~~five~~ (5) days to notify the agency of its PE determination. The PE period ends with the earlier of:

(A) The day the agency receives the SoonerCare application form as described in OAC 317:35-5-60 and an eligibility determination is made by the agency; or

(B) If a SoonerCare application is not received, the last day of the month following the month in which the PE determination was made.

(2) **Agency approval of PE.** When the OHCA receives a timely and completed HPE application, a case number and, if needed, SoonerCare member ID is assigned to the member by the agency. Qualified hospitals will be able to review member enrollment and eligibility, once those members have been entered into the system by the OHCA, for claims billing and member eligibility verification.

(3) **Incomplete HPE applications.** Upon receiving a HPE ~~Application~~application, the OHCA reviews it for completeness and correctness. The HPE application is considered incomplete if it is not filled out in its entirety (e.g., the applicant's first or last name is not provided on the application) or if the application is not filed timely with the OHCA. When the HPE application is determined to be incomplete, the HPE application is returned to the AHE or the HPE program administrator at the qualified hospital to correct the application errors or amend the HPE application. To maintain the original PE certification period, the qualified hospital must return the completed or corrected HPE application to the agency within ~~five~~ (5) working days.

(4) **Applicant appeal.** The HPE applicant cannot appeal the PE determination made by a qualified hospital or the expiration date of the PE period.

(5) **Applicant ineligibility.** Applicants ineligible for the HPE program are individuals who do not meet the HPE criteria, individuals who have previously been enrolled in the HPE program within the last ~~365~~three hundred sixty-five (365) days, and individuals currently enrolled in SoonerCare. Individuals currently enrolled in SoonerPlan ~~Family Planning~~family planning are not eligible for HPE family planning services, but may be eligible for other programs under HPE. When the OHCA receives a HPE application from a qualified hospital for an ineligible applicant (~~e.g., the applicant has been previously enrolled in the HPE program within the last 365 days~~)[e.g., the applicant has been previously enrolled in the HPE program within the last three hundred sixty-five (365) days], the OHCA will disenroll the individual

from the HPE program immediately and notify the hospital of the error. The hospital will be responsible for following up with that individual to notify them of their disenrollment from the HPE program. If the applicant is not currently enrolled into SoonerCare, the applicant may submit a full SoonerCare application and receive a full eligibility determination by the OHCA. HPE services provided to ineligible applicants, other than persons currently enrolled into SoonerCare or SoonerPlan ~~Family Planning~~family planning program, may not be eligible for reimbursement by the OHCA.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

**PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT
(EPSDT) PROGRAM/CHILD-HEALTH SERVICES**

317:30-3-65.8. Dental services

(a) At a minimum, dental services include relief of pain and infection; limited restoration of teeth and maintenance of dental health; and oral prophylaxis every ~~184 days~~ six (6) months. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. Other dental services include inpatient services in an eligible participating hospital, and amalgam and composite restorations, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, acrylic partial and lingual arch bars; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized ~~{refer to Oklahoma Administrative Code 317:30-5-696(3)(2) for amount, duration and scope}~~].

(b) Dental ~~screenings~~ screenings should begin at the first sign of tooth eruption by the primary care provider and with each subsequent visit to determine if the member needs a referral to a dental provider. Dental examinations by a qualified dental provider should begin by age one (1) (unless otherwise indicated) and every six (6) months to one (1) year thereafter. Additionally, members should be seen for prophylaxis once every ~~184 days~~ six (6) months, if indicated by risk assessment. All other dental services for relief of pain and infection, restoration of teeth and maintenance of dental health should occur as the provider deems necessary.

(c) Separate payment will be made to the member's primary care provider for the application of fluoride varnish during the course of a child-health screening for members ages six (6) months to sixty (60) months. Reimbursement is limited to two applications per year ~~by eligible providers who have attended an OHCA approved training course related to the application of fluoride varnish.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.** The OHCA Dental Program provides basic medically necessary treatment. The services listed below are compensable for members twenty-one (21) years of age and over without prior authorization.

(A) ~~Dental coverage for adults is limited to:~~ **Comprehensive oral evaluation.** The comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation must precede any images, and chart documentation must include image interpretations, six-point periodontal charting, and both medical and dental health history of the member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member once every six (6) months. An examination must precede any images, and chart documentation must include image interpretations, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images. Documentation must indicate medical necessity and diagnostic findings. Images must be properly labeled with date and member name. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of panoramic film exposure is not to rule out or evaluate caries. Prior authorization and a narrative detailing medical necessity are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental prophylaxis.** Dental prophylaxis is provided once every six (6) months along with topical application of fluoride.

(F) **Periodontal Maintenance.** This procedure is provided once every six (6) months for members who have a history of periodontitis and are no longer eligible for oral prophylaxis.

(G) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered per Oklahoma Administrative Code (OAC) 317:30-5-2 (DD) (i) through (iv).

(H) **Medically necessary extractions.** Medically necessary extractions, as defined in OAC 317:30-5-695. Tooth extraction must have medical need documented.

(I) **Medical and surgical services.** Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(J) **Additional services.** Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

~~(i) Medically necessary extractions, as defined in Oklahoma Administrative Code (OAC) 317:30-5-695. Tooth extraction must have medical need documented;~~

~~(ii) Limited oral examinations and medically necessary images, as defined in OAC 317:30-5-695, associated with the extraction or with a clinical presentation with reasonable expectation that an extraction will be needed;~~

~~(iii) Smoking and tobacco use cessation counseling; and~~

~~(iv) Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.~~

~~(B) Payment is made for dental care for adults residing in private intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age twenty one (21).~~

~~(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior authorization before delivery of dental service, with the exception of evaluation and~~

~~extractions. All requests must be filed on the currently approved American Dental Association (ADA) form and must include diagnostic images, six point periodontal charting, narratives and comprehensive treatment plans. The Oklahoma Health Care Authority (OHCA) will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:-~~

- ~~(i) Comprehensive oral evaluation;~~
- ~~(ii) Two (2) bitewing images;~~
- ~~(iii) Prophylaxis;~~
- ~~(iv) Fluoride application;~~
- ~~(v) Limited restorative procedures; and-~~
- ~~(vi) Periodontal scaling/root planing.~~

~~(2) **Home and community-based services (HCBS) waiver for the intellectually disabled.**~~

~~All providers participating in the HCBS must have a separate contract with the OHCA to provide services under the HCBS. Dental services are defined in each waiver and must be prior authorized.~~

~~(3)(2) **Children.** The OHCA Dental Program for children provides ~~the basic~~ medically necessary treatment. For services rendered to a minor, the minor's parent or legal guardian must provide a signed, written consent prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. The services listed below are compensable for members under twenty-one (21) years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults per OAC 317:30-5-696.1. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.~~

~~(A) **Comprehensive oral evaluation.** This procedure should precede any images, and chart documentation must include image interpretations, caries risk assessment, six point periodontal charting (as applicable), and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure. A comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation must precede any images, and chart documentation must include image interpretations, caries risk assessment, six-point periodontal charting, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.~~

~~(B) **Periodic oral evaluation.** This procedure may be provided for a member ~~of record~~ once every six (6) months. An examination ~~should~~ must precede any images, and chart documentation must include image interpretations, ~~caries risk assessment~~, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.~~

~~(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.~~

~~(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. ~~A clinical examination must precede any images, and chart documentation must include member history, prior images, caries risk assessment, the~~~~

~~six point periodontal charting (as applicable), and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. A clinical examination must precede any images, and chart documentation must indicate medical necessity and diagnostic findings. Images must be properly labeled with date and member name.~~ Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films and two (2) bitewings are considered full mouth images. Full mouth images as noted above or traditional [minimum of twelve (12) periapical films and two (2) posterior bitewings] are allowable once in a three (3) year period and must be of diagnostic quality. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through eighteen (18) years of age and is compensable once every thirty-six (36) months if medical necessity is documented.

(F) **Interim caries arresting medicament application.** This service is available for primary and permanent teeth once every ~~one hundred eighty four (184) days~~ six (6) months for two (2) occurrences per tooth in a lifetime. The following criteria must be met for reimbursement:

- (i) A member is documented to be unable to receive restorative services in the typical office environment within a reasonable amount of time;
- (ii) A tooth that has been treated should not have any non-carious structure removed;
- (iii) A tooth that has been treated should not receive any other definitive restorative care for three (3) months following an application;
- (iv) Reimbursement for extraction of a tooth that has been treated will not be allowed for three (3) months following an application; and
- (v) The specific teeth treated and number and location of lesions must be documented.

(G) **Dental prophylaxis.** This procedure is provided once every ~~one hundred eighty four (184) days~~ six (6) months along with topical application of fluoride.

(H) Periodontal Maintenance. This procedure is provided once every six (6) months for members who have a history of periodontitis and are no longer eligible for oral prophylaxis.

~~(H)~~(I) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

- (i) Stainless steel crowns are allowed if:
 - (I) The child is five (5) years of age or under;
 - (II) Seventy percent (70%) or more of the root structure remains; or
 - (III) The procedure is provided more than twelve (12) months prior to normal exfoliation.
- (ii) Stainless steel crowns are treatment of choice for:

- (I) Primary teeth treated with pulpal therapy, if the above conditions exist;
 - (II) Primary teeth where three (3) surfaces of extensive decay exist; or
 - (III) Primary teeth where cuspal occlusion is lost due to decay or accident.
- (iii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.
- (iv) Placement of a stainless steel crown is allowed once for a minimum period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

~~(J)~~ **(J) Stainless steel crowns for permanent teeth.** The use of any stainless steel crowns is allowed as follows:

- (i) Stainless steel crowns are the treatment of choice for:
 - (I) Posterior permanent teeth that have completed endodontic therapy if three (3) or more surfaces of tooth is destroyed;
 - (II) Posterior permanent teeth that have three (3) or more surfaces of extensive decay; or
 - (III) Where cuspal occlusion is lost due to decay prior to age sixteen (16) years.
- (ii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.
- (iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time.

~~(K)~~ **(K) Pulpotomies and pulpectomies.**

- (i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre-and post-operative periapical images must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:
 - (I) Primary molars having at least seventy percent (70%) or more of their root structure remaining or more than twelve (12) months prior to normal exfoliation;
 - (II) Tooth numbers O and P before age five (5) years;
 - (III) Tooth numbers E and F before six (6) years;
 - (IV) Tooth numbers N and Q before five (5) years;
 - (V) Tooth numbers D and G before five (5) years.
- (ii) Therapeutic pulpotomies and pulpal debridement are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one (1) year or if seventy percent (70%) or more of root structure is remaining.

~~(K)~~ **(K) Endodontics.** ~~Payment is made for the services provided in accordance with the following:~~

- ~~(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.~~
- ~~(ii) The provider documents history of member's improved oral hygiene and flossing ability in records.~~
- ~~(iii) Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior and/or any posterior root canals.~~
- ~~(iv) Pre and post operative periapical images must be available for review.~~
- ~~(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.~~

~~(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for twenty-four (24) month post completion.~~

~~(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.~~

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six (6) months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than five (5) millimeters below the crest of the alveolar ridge.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim ~~should~~must be those of the missing teeth.

(V) Post-operative bitewing images must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four (4) mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Pre and post-operative images must be available.

(M) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four (4) occurrences per year and is not separately reimbursable, if provided on the same date as IV sedation, non-intravenous conscious sedation, or general anesthesia. The medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date ~~by the same provider~~ as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation, or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and/or the dentist, it must be medically necessary.

(N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or mineral trioxide aggregate (MTA) materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals

used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(O) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after sixty (60) days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **Smoking and tobacco use cessation counseling.** ~~Smoking and tobacco use cessation counseling is covered when performed utilizing the five (5) intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow up. Up to eight (8) sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nurses, and maternal/child health licensed clinical social workers with a Tobacco Treatment Specialist Certification (TTS-C). Chart documentation must include a separate note that addresses the 5A's, separate signature, and the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit.~~ Smoking and tobacco use cessation counseling is covered per OAC 317:30-5-2 (DD) (i) through (iv).

(Q) **Diagnostic casts and/or oral/facial images.** Diagnostic casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. If cast and/or images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned. Providers will be reimbursed for either the study model or images.

(i) ~~Documentation of photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic or paper claim.~~

(ii) ~~Oral/facial photographic images are allowed under the following conditions:~~

(I) ~~When radiographic images do not adequately support the necessity for requested treatment.~~

(II) ~~When photo images better support medical necessity for the requested treatment rather than diagnostic models.~~

(III) ~~If a comprehensive orthodontic workup has not been performed.~~

(iii) ~~For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspatation of teeth.~~

(I) ~~Maximum intercuspatation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.~~

(II) ~~Intercuspatation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.~~

(iv) ~~Study models or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will~~

be denied.

(Q) **Additional services.** Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

(3) **1915(c) home and community-based services (HCBS) waivers.** Dental services are defined in each waiver and must be prior authorized.

317:30-5-698. Services requiring prior authorization

(a) **Prior authorizations.** Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis [See Oklahoma Administrative Code (OAC) 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation.

(b) **Requests for prior authorization.** Requests for prior authorization are filed on the currently approved American Dental Association (ADA) form. Requests for prior authorization, and any related documents, must be submitted electronically through the OHCA secure provider portal. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) **Prosthodontic services.** Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) **Adults.** Listed below are examples of services requiring prior authorization for members twenty-one (21) years of age and over/older. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, with the prior authorization requesting all needed treatment. The images, digital media, and photographs must be of sufficient type and quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. Documentation of a periodontal evaluation with six (6) point measurements for teeth to remain must be included with requests.

(1) **Removable prosthetics.**

(A) This includes full and partial dentures.

(i) One (1) per every five (5) years is available for adults under twenty-five (25) years of age.

(ii) One (1) per every seven (7) years is available for adults twenty-five (25) years of age and over.

(iii) Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(B) Partial dentures are allowed for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch. Provider must indicate which teeth will be replaced.

(2) **Periodontal scaling and root planing.** Procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure requires that each tooth involved have three (3) or more of the six-point measurements (probing pocket depths) equivalent to four (4) millimeters or greater, and image supported alveolar bone loss. Image supported subgingival calculus, and bleeding on probing,

must be demonstrated on multiple teeth for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing will not be approved in conjunction with recent oral prophylaxis.

(3) Scaling in the presence of generalized moderate or severe gingival inflammation.
Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and sub-gingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of five (5) mm or greater. This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

~~(d)~~**(e) Children.** Listed below are examples of services requiring prior authorization for members under twenty-one (21) years of age and eligible intermediate care facilities for individuals with intellectual disabilities (ICF/IID) residents. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. ~~prior authorization requesting all needed treatments. The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request.~~ The images, digital media, and photographs must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

~~(1) Endodontics.~~ Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's oral hygiene and flossing ability in the member's records. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the Oklahoma Health Care Authority (OHCA) on request for endodontics.

~~(A) Anterior endodontics.~~ Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior root canals. All rampant, active caries should be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

- ~~(i) Permanent teeth only;~~
- ~~(ii) Accepted ADA materials must be used;~~
- ~~(iii) Pre and post operative periapical images must be available for review;~~
- ~~(iv) Providers are responsible for any follow up treatment required by a failed endodontically treated tooth within twenty four (24) months post completion;~~
- ~~(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor; and~~
- ~~(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.~~

(B) Posterior endodontics. The guidelines for this procedure are as follows:

- ~~(i) The provider must document the member's oral hygiene and flossing ability in the member's records.~~
- ~~(ii) Teeth that require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure may not be approved for root canal therapy.~~
- ~~(iii) Pre and post-operative periapical images must be available for review.~~
- ~~(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion.~~
- ~~(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.~~
- ~~(vi) Only ADA accepted materials are acceptable under the OHCA policy.~~
- ~~(vii) Posterior endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.~~
- ~~(viii) Endodontics will not be considered if:
 - ~~(I) An opposing tooth has super erupted;~~
 - ~~(II) Loss of tooth space is one-third or greater;~~
 - ~~(III) Opposing second molars are involved unless prior authorized;~~
 - ~~(IV) The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up; or~~
 - ~~(V) All rampant, active caries must be removed prior to requesting posterior endodontics.~~~~
- ~~(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.~~

(1) Endodontics. Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's improved oral hygiene and flossing ability and submit it with the prior authorization request to be considered when requesting endodontic therapy for multiple teeth. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the Oklahoma Health Care Authority (OHCA) on request for endodontics.

(A) Payment is made for services provided in accordance with the following guidelines:

- (i) Permanent teeth only;
- (ii) Only ADA accepted materials are acceptable under the OHCA policy;
- (iii) Pre and post-operative periapical images must be available for review;
- (iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion;
- (v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor. Approval of second molars is contingent upon proof of medical necessity; and
- (vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown due to lack of tooth structure.

(B) Endodontics will not be considered if:

- (i) An opposing tooth has super erupted;

(ii) The tooth impinges upon space of adjacent tooth space by one third or greater;

(iii) Fully restored tooth will not be in functional occlusion with opposing tooth;

(iv) Opposing second molars are involved unless prior authorized;

(v) The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(C) All rampant, active caries must be removed prior to requesting endodontics.

(D) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are sixteen (16) ~~years of age or older and adults residing in private ICF/HD and who have been approved for ICF/HD level of care~~ through twenty (20) years of age. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure:

(i) All rampant, active caries must be removed prior to requesting any type of crown;

(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function;

(iii) The clinical crown is fractured or destroyed by one-half or more; and

(iv) Endodontically treated teeth must have three (3) or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed above in (A)(i) through (iv) ~~should~~ must be clearly visible on the submitted images when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown. ~~Non authorized restorative codes may be used if available.~~

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Chart documentation must include the OHCA caries risk assessment form demonstrating member is at a low to moderate risk and be submitted with the prior authorization request for crowns for permanent teeth.

(G) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for forty-eight (48) months post insertion.

(3) ~~Cast frame partial~~ **Partial dentures.** ~~This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch for members sixteen (16) through twenty (20) years of age. Provider must indicate which teeth will be replaced. Members must have improved oral hygiene documented for at least twelve (12) months in the provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two (2) years post insertion.~~

(A) This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch for members sixteen (16) years of age and older.

(B) Interim partial dentures are available for children five (5) years of age and older.

(C) Provider must indicate which teeth will be replaced.

(D) Members must have improved oral hygiene documented for at least twelve (12) months in the provider's records and submitted with prior authorization request to be considered.

(E) Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(F) This appliance includes all necessary clasps and rests.

~~(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three (3) or more missing teeth in the same arch for members twelve (12) through sixteen (16) years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.~~

~~(5)(4) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.~~

~~(6)(5) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members seventeen (17) through twenty (20) years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least eighteen (18) months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.~~

~~(7)(6) **Periodontal scaling and root planing.** Procedure is designed for the removal of calculus or tissue that is contaminated and may require anesthesia and some soft tissue removal. This procedure requires that each tooth have three (3) or more of the six point measurements four (4) millimeters or greater, and have multiple areas of image supported bone loss, subgingival calculus and must involve two (2) or more teeth per quadrant for consideration. This procedure is not allowed in conjunction with any other periodontal surgery. Procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure requires that each tooth involved have three (3) or more of the six-point measurements (probing pocket depths) equivalent to four (4) millimeters or greater, and image supported alveolar bone loss. Image supported subgingival calculus, and bleeding on probing, must be demonstrated on multiple teeth for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing will not be approved in conjunction with recent oral prophylaxis.~~

~~(8)(7) **Scaling in the presence of generalized moderate or severe gingival inflammation.** Procedure is designed for removal of plaque, calculus and stain from supra- and sub- gingival tooth surfaces when there is generalized moderate or severe gingival inflammation, as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (bone loss). This procedure is only performed after a comprehensive evaluation has been completed and is not performed in conjunction with a prophylaxis. Procedure is designed for removal of plaque, calculus and stain from supra- and sub- gingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and sub- gingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of five (5) mm or greater.~~

This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

317:30-5-699. Restorations

~~(a) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 24 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. Providers must document type of isolation used in treatment progress notes. The provider is responsible for follow up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible.~~

(1) The Oklahoma Health Care Authority utilization parameters allow only one (1) permanent restorative service to be provided per tooth per twenty-four (24) months.

(2) Additional restorations may be authorized upon approval of OHCA in cases of trauma.

(3) The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible.

(4) Providers must document type of isolation used in treatment progress notes.

(5) For members who are under twenty-one (21) years of age and who are receiving a restoration are eligible within three (3) months for consideration of a single crown if endodontically treated.

(b) Coverage for dental restorations. Restoration of incipient lesions is not considered medically necessary treatment. Any diagnosis not supported by images requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered, for adults and children, as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one (1) surface restoration.

(2) If any two (2) separate surfaces on a posterior tooth are restored at the same appointment, it is a two (2) surface restoration.

(3) If any three (3) separate surfaces on a posterior tooth are restored at the same appointment, it is a three (3) surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four (4) surface restoration.

(5) If any two (2) separate surfaces on an anterior tooth are restored at the same appointment, it is a two (2) surface restoration.

(6) If any three (3) separate surfaces on an anterior tooth are restored at the same appointment, it is a three (3) surface restoration.

(7) An incisal angle restoration is defined as one (1) of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four (4) or more separate surfaces on a posterior tooth are restored at the same appointment it is a four (4) surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

317:30-5-700. Orthodontic services

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age at the time the request for prior authorization for treatment is received.

In order to be eligible for SoonerCare orthodontic services, members must be referred through an OHCA contracted primary care dentist using the DEN-2 form found on the Oklahoma Health Care Authority (OHCA) website; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

- (1) The member has had a caries free initial visit; or
- (2) Has all decayed areas restored and has remained caries free for twelve 12 months; and
- (3) Has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

- (1) A handicapping malocclusion, as measured on the Oklahoma Health Care Authority (OHCA) Handicapping Labio-Lingual Deviation Index of Malocclusion (DEN-6) form, with a minimum score of thirty (30);
- (2) Any classification secondary to cleft palate or other maxillofacial deformity;
- (3) If a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;
- (4) Fixed appliances only; and
- (5) Permanent dentition with the exception of cleft defects.

(d) Reimbursement for orthodontic services is limited to:

- (1) Orthodontists, or
- (2) General or Pediatric dental practitioners who have completed at least two-hundred (200) certified hours of continuing education in the field of orthodontics practice and submit for review at least twenty-five successfully completed comprehensive cases. Of these twenty-five comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under-served area. The comprehensive cases submitted ~~should~~must be of a complexity consistent with type of handicapping malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one (1) of each of the following types:

- (i) Deep overbite where multiple teeth are impinging upon the soft tissue of the palate;
- (ii) Impacted canine or molar requiring surgical exposure;
- (iii) Bilateral posterior crossbite requiring fixed rapid palatal expansion; and
- (iv) Skeletal class II or III requiring orthognathic surgery.

(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.

(C) The OHCA requires all general dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least twenty (20) continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be

submitted to OHCA Dental Unit every three (3) years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of twenty-four (24) months of therapy.

(e) The following limitations apply to orthodontic services:

- (1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare program and no requests should be submitted;
- (2) All orthodontic procedures require prior authorization for payment;
- (3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year. Treatment year is determined by date of banding; and
- (4) The member must be SoonerCare-eligible and under eighteen (18) years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired. It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age eighteen (18).

(f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

(g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA members is equivalent to that of private pay patients.

(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

317:30-5-700.1. Orthodontic prior authorization

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age, at the time the request for prior authorization for treatment is received, per Oklahoma Administrative Code 317:30-5-700. The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be submitted to the Dental Unit of the Oklahoma Health Care Authority (OHCA) Dental Program when the member has a total score of not less than thirty (30) points or meets other eligibility criteria in paragraph (d).

- (1) Completed ~~currently approved American Dental Association (ADA) dental claim form~~ prior authorization requesting all needed treatments;
- (2) Complete and scored Handicapping Labio-Lingual Deviation (HDL) Index with Diagnosis of Angle's classification;
- (3) Detailed description of any oral maxillofacial anomaly;
- (4) Estimated length of treatment;
- (5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;
- (6) Cephalometric images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;

- (7) Completed OHCA caries risk assessment form;
 - (8) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service; and
 - (9) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.
- (b) All images and required documentation must be submitted in one (1) package. OHCA is not responsible for lost or damaged materials.
- (c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA orthodontic consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.
- (d) Some children not receiving a minimum score of thirty (30) on the HDL Index may have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exception section found on the HLD. The following guidelines and restrictions apply to other conditions:
- (1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child;
 - (2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child;
 - (3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (e.g., a child's teacher, primary care physician, behavioral health provider, school counselor);
 - (4) Objective evidence must be submitted with the HLD;
 - (5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA orthodontic consultant must review the data and use his or her professional judgment to score the value of the conditions; and
 - (6) The OHCA orthodontic consultant may consult with and utilize the opinion of the orthodontist who completes the form.
- (e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the member's age precludes approval, a computer generated notice is issued to the provider and member with notice of the denial, the reason for the denial, and appeal rights [see Oklahoma Administrative Code (OAC) 317:2-1 for grievance procedures and processes].
- (f) Orthodontic treatment and payment for the services are approved within the scope of the SoonerCare program. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.
- (1) Approval of orthodontic treatment is given in accordance with the following:
 - (A) Authorization for the first year begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six (6) adjustments. It is expected that orthodontic members be seen every four (4) to eight (8) weeks for the duration of active treatment.
 - (B) Subsequent adjustments will be authorized in one (1) year intervals and the treating orthodontist must provide a comprehensive progress report at the twenty-four (24) month interval.
 - (C) All approved treatment is included on the original prior authorization and will include the total payment for that treatment year.
 - (2) Claim and payment are made as follows:
 - (A) Payment for comprehensive treatment includes the banding, wires, adjustments as

well as all ancillary services, including the removal of appliances, and the construction and placing of retainers.

(B) Payment is not made for comprehensive treatment beyond thirty-six (36) months.

(g) If the member moves from the geographic area or shows a need to change their provider, then the provider who received the yearly payment is financially responsible until completion of that member's orthodontic treatment for the current year.

(h) If the provider who received yearly payment does not agree to be financially responsible, then the OHCA may recoup funds paid for the member's orthodontic treatment.

(i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After review is completed, these materials are returned to the orthodontist.

~~(j) Study models or oral/facial images must be diagnostic and meet the following requirements:~~

~~(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.~~

~~(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.~~

~~(3) 3-D model images are preferred.~~

~~(4) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be seen on the study models.~~

~~(5) For photographic images, the oral/facial portfolio must show a view of the complete lower arch, complete upper arch, and left and right maximum intercuspatation of teeth.~~

~~(A) Maximum intercuspatation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.~~

~~(B) Intercuspatation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.~~

(j) Electronic images of casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. Providers will be reimbursed for either the study model or images when obtained for orthodontic evaluation and/or therapy.

(1) Documentation of casts and/or photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic claim.

(2) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspatation of teeth.

(A) Maximum intercuspatation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(B) Intercuspatation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(3) 3-D model images or photographic images not in compliance with the diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

317:30-5-705. Billing and reimbursement

~~Billing for dental services may be submitted on the currently approved version of the American Dental Association (ADA) claim form. Diagnosis codes are requested to be listed in box 34 of the current ADA dental claim form. Electronic submission must be made on the HIPAA compliant Form 837D.~~

(a) Dental claims, and any related documents, must be submitted electronically or through the OHCA secure provider portal. Electronic submission must be made on the HIPAA compliant Form 837D.

(b) Billing and reimbursement methodology, including copayments, are outlined in the Oklahoma Medicaid State Plan.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

SUBCHAPTER 1. ADMINISTRATIVE APPEALS

317:2-1-2. Appeals

(a) Request for appeals.

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an agency action, the date on the written notice shall not be included. The last day of the timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the agency receives it.

(b) Member process overview.

(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to initiate an appeal, the member must file a LD-1 (Member Complaint/Grievance Form) within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances serving as the basis for appeal.

(3) If the LD-1 form is not received timely, the OHCA administrative law judge (ALJ) will cause to be issued a letter stating the appeal will not be heard. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to 68 O.S. § 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.

(5) OHCA will advise members that if assistance is needed in reading or completing the grievance form, arrangements will be made to provide such assistance.

(6) Upon receipt of the member's appeal, a fair hearing before the OHCA ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member, and/or his/her designated authorized representative, must appear at the hearing, either in person or telephonically. ~~Requests for a telephone hearing must be received in writing on OHCA's LD-4 (Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date. Telephonic hearing requests will only be granted by the OHCA's chief executive officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.~~ The preferred method for a hearing is telephonically, requests for an in-person hearing must be received in writing on OHCA's Form LD-4 (Request for In-Person Hearing) no later than ten (10) calendar days prior to the scheduled hearing date.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The OHCA ALJ's decision may in certain instances be appealed to the CEO of the OHCA, or his or her designated independent ALJ, which is a record review at which the parties do not appear (OAC 317:2-1-13).

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless:

(A) The appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.5;

(B) The OHCA cannot reach a decision because the appellant requests a delay or fails to take a required action, as reflected in the record;

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record; or

(D) The appellant filed a request for an appeal of a denied step therapy exception request, pursuant to OAC 317:2-1-18.

(9) Tax warrant intercept appeals will be heard directly by the OHCA ALJ. A decision is normally rendered by the OHCA ALJ within twenty (20) days of the hearing ~~before the ALJ~~.

(c) Provider process overview.

(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(d)(2).

(2) All provider appeals are initially heard by the OHCA ALJ under OAC 317:2-1-2(d)(2).

(A) In order to initiate an appeal, a provider must file the appropriate LD form within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.

(B) Except for OHCA Program Integrity audit appeals, if the appropriate LD form is not received timely, the OHCA ALJ will cause a letter to be issued stating that the appeal will not be heard.

(C) A decision ordinarily will be issued by the OHCA ALJ within forty-five (45) days of the close of all evidence in the appeal.

(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the OHCA ALJ's decision is appealable to OHCA's CEO, or his or her designated independent ALJ.

(d) OHCA ALJ jurisdiction. The OHCA ALJ has jurisdiction of the following matters:

(1) Member appeals.

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee-for-service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the OHCA ALJ. A decision will be rendered by the OHCA ALJ within twenty (20) days of the hearing;

(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the OHCA ALJ. A decision by the OHCA ALJ will ordinarily be rendered within twenty (20) days of the hearing ~~before the ALJ~~. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA;

(G) Appeals of insureds participating in Insure Oklahoma which are authorized by OAC 317:45-9-8; ~~and~~

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310; and

(I) Requests for State fair hearing arising from a member's appeal of a managed care adverse benefit determination.

(2) Provider appeals.

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. § 85.1 et seq.;

(E) Drug rebate appeals;

(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;

(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;

(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, supplemental payment, fees or penalties as specifically provided in OAC 317:2-1-15; and

(I) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.

(J) Request for a State fair hearing arising from provider's appeal of managed care audit findings, for-cause or immediate termination of the provider's managed care contract, or managed care claims denial.

317:2-1-13. Appeal to the chief executive officer

(a) The Oklahoma Health Care Authority offers approximately forty (40) different types of administrative appeals. Some of the appeals are appealable to the chief executive officer (CEO) and some are not. The following appeals are subject to further review upon timely submission of a request for CEO appeal and may be heard/reviewed by the CEO, or his or her designated independent administrative law judge (ALJ), following the decision of an administrative law judge/the OHCA ALJ:

(1) Appeals under Oklahoma Administrative Code (OAC) 317:2-1-2(d)(1)(A) to (d)(1)(H), with the exception of subsection (d)(1)(E); and

(2) Appeals under OAC 317:2-1-2(d)(2)(A) to (d)(2)(I), with the exceptions of subsections (d)(2)(D),(E),(F),(G), and (I).

(b) Appeals to the CEO must be filed with the OHCA within thirty (30) days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the CEO.

(d) Appeals to the CEO under (a) of this Section may be filed by the provider, member, or agency. The CEO will ordinarily render decisions within sixty (60) days of the receipt of the appeal.

(e) The CEO may only designate an independent ALJ at another state agency, as established in the Oklahoma State Medicaid Plan and approved by the Centers for Medicare and Medicaid Services, to review a CEO appeal.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

**PART 27. INDEPENDENT PHYSICAL THERAPISTS AND PHYSICAL THERAPISTS
ASSISTANTS**

317:30-5-291. Coverage by category

Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed physical therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code (OAC) 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

(4) **Alternative treatments for pain management.** Refer to OAC 317:30-5-725.

PART 81. CHIROPRACTORS

317:30-5-720. Eligible providers

~~In order to be eligible for payment, the provider of chiropractic services must have a current Memorandum of Agreement with the Oklahoma Health Care Authority.~~ **Chiropractors.**

(1) Must be appropriately licensed, in good standing in the state in which they practice, and working in accordance with the Oklahoma Chiropractic Practice Act or other applicable statute(s); and

(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide chiropractic services.

317:30-5-721. Coverage by category

Payment is made to chiropractors as set forth in this Section.

(1) **Children.** There is no coverage for children.

(2) **Adults.** There is no coverage for adults.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

(4) **Manual spinal manipulation services for pain management.** Refer to Oklahoma Administrative Code 317:30-5-724.

PART 82. ALTERNATIVE TREATMENTS FOR PAIN MANAGEMENT

317:30-5-722. General

Alternative treatments for pain management are non-pharmacological treatments recommended by a physician or other licensed practitioner of the healing arts for adults age twenty-one (21) or older with acute, subacute, and chronic spinal/back pain or injury. Treatments are intended to reduce pain, increase mobility, optimize function, and decrease use and misuse of opioid medications and may include the services listed in Part 82, of this Chapter.

317:30-5-723. Eligible providers

(a) Manual spinal manipulation. Providers must meet the requirements outlined at Oklahoma Administrative Code (OAC) 317:30-5-720.

(b) Physical therapy (PT) for alternative treatments for pain management. Providers must meet the requirements outlined at OAC 317:30-5-290.1.

317:30-5-724. Manual spinal manipulation

Chiropractic services are limited to manual spinal manipulation. This includes the manipulation of the five (5) regions of the spinal column for the treatment of back pain in a member with a primary diagnosis of acute or chronic pain and is performed by a licensed chiropractor.

(1) Medical necessity. All manual spinal manipulation services should be determined to be medically necessary for the affected member. Documentation in the member's plan of care should support the medical necessity of the need for manual spinal manipulation services. The Oklahoma Health Care Authority (OHCA) will serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-3-1(f) for policy on medical necessity.

(2) Documentation/requirements. All documentation submitted to request manual spinal manipulation services should demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(A) Evaluations. One (1) initial evaluation and one (1) re-evaluation, for chiropractic manual spinal manipulation, are allowed per calendar year and do not require a PA.

(B) Prior authorization (PA). Documentation, for a PA request, will include the following:

- (i) The member is over twenty-one (21) years of age;
- (ii) Attestation stating that manual spinal manipulation services are being used in place of opioid treatment for pain or used to decrease the use of opioids;
- (iii) Primary diagnosis of acute or chronic spinal pain or neuromusculoskeletal disorder related to the spinal column;
- (iv) Plan of care that is designed for the treatment of spinal pain;
- (v) Signed informed consent for care;
- (vi) For full guidelines, please refer to www.okhca.org/mau.

(C) Subsequent PA requests. Requests for a subsequent PA will include the following:

- (i) All documentation found at (2)(B)(i) through (v) of this Section;
- (ii) Medical records that document that the treatments meet the functional needs of the member;
- (iii) Treatment goals for acute pain/injury, chronic pain management, or chronic back pain;
- (iv) Treatment evaluations that should demonstrate improvement, including but not limited to, improved function, decreased use of pain medications, increased activity level;
- (v) Records showing persistent or recurrent conditions;

(vi) For full guidelines, please refer to www.okhca.org/mau.

(3) Frequency/coverage.

(A) SoonerCare covers up to twelve (12) manual spinal manipulation visits per calendar year with an approved PA.

(B) Manual spinal manipulation for the treatment of acute or chronic back pain is the only chiropractic service covered by SoonerCare.

(4) Reimbursement. All alternative treatments for pain management services, that are outlined in Part 82 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(5) Discontinuation of services.

(A) If the member's condition is not improving, or the member's condition is regressing, services will not be considered medically necessary.

(B) The OHCA may withdraw authorization of payment at any time if it is determined that the member and/or provider is not in compliance with any of the requirements set forth in this Section.

(6) Non-covered services.

(A) Manual spinal manipulation provided solely for maintenance.

(B) Chiropractor services that are not for the alternative treatments of pain management listed in Part 82 of this Chapter.

(C) Manual spinal manipulation services that are provided in a setting other than the chiropractor's office, including but not limited to, inpatient or outpatient hospitals, nursing facilities, rest homes, or the member's home.

317:30-5-725. Physical therapy (PT) for alternative treatments for pain management

PT is used to improve a person's ability to move, reduce or manage pain, restore function, and prevent disability. For pain management, PT is provided in a non-hospital based setting with the aim of decreasing pain and suffering while improving physical and mental functioning.

(1) Medical necessity. All services/diagnosis found in the full guidelines at www.okhca.org/mau for alternative treatments for pain management should be determined to be medically necessary for the affected member. Documentation in the member's plan of care should support the medical necessity of the need for alternative treatments for pain management services. The Oklahoma Health Care Authority (OHCA) will serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-3-1(f) for policy on medical necessity.

(2) Documentation/requirements. All documentation submitted to request services should demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(A) Evaluations. One (1) initial PT evaluation and one (1) PT re-evaluation, when necessary, will be covered per calendar year at a non-hospital-based setting and do not require a PA, when the service is performed for the evaluation of therapy services related to alternative treatments of pain management.

(B) Prior authorization (PA). Documentation, for a PA request, will include the following:

(i) The member is over twenty-one (21) years of age;

(ii) A prescription or a referral from the member's physician or other licensed practitioner of the healing arts, dated within the previous ninety (90) days requesting the PT services for pain management;

(iii) Attestation stating that PT services are being used in place of opioid treatment for pain or used to decrease the use of opioids;

(iv) Medical records, from the member's physician or other licensed practitioner of the healing arts, documenting the need for the pain management referral;

(v) Documentation from the physical therapist that supports the need for the requested services;

(vi) A detailed report, from the physical therapist, that is gathered from any tool, test, or measure;

(vii) Measurable goals that includes the following:

(I) Timeframe;

(II) Baseline;

(III) Conditions for how goals are expected to be met;

(IV) A statement of rationale; and

(V) Prognosis for achievement.

(viii) A detailed intervention plan that includes:

(I) Frequency and duration of the services and the anticipated length of the intervention;

(II) Location of where the services are provided;

(III) Member and/or family/caregiver involvement in the management and carry-over of the intervention;

(IV) Reasons if the intervention was unsuccessful.

(ix) A completed therapy PA request form;

(x) For full guidelines, please refer to www.okhca.org/mau.

(C) Subsequent PA requests. Requests for a subsequent PA will include the following:

(i) All documentation found at (2)(B) (i) through (viii) of this Section;

(ii) Detailed listing of previous goals, including instances of which goals were unmet and why they were not achieved;

(iii) Treatment goals for acute pain/injury, chronic pain management, or chronic back pain;

(iv) Records showing persistent or recurrent conditions;

(v) Treatment evaluations that show avoidance/prevention or reduction of opioid use;

(vi) A completed therapy PA request form;

(vii) For full guidelines, please refer to www.okhca.org/mau.

(3) Frequency/coverage. A PA for PT for adult treatment of pain management services may be approved for a total of forty-eight (48) units per calendar year. A PT unit for the treatment of pain management in adults is 15 minutes. A visit may consist of multiple units of service on the same date, the time for units of service is added together and rounded up only once per visit.

(4) Reimbursement. All alternative treatments for pain management services, that are outlined in Part 82 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(5) Discontinuation of services.

(A) If the member's condition is not improving, or the member's condition is regressing, then services will not be considered medically necessary.

(B) The OHCA may withdraw authorization of payment at any time if it is determined that the member and/or provider is not in compliance with any of the requirements set forth in this section.

(6) Non-covered services.

(A) PT provided solely for maintenance.

(B) Therapeutic or physical modalities used to augment a PT program.

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

**SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE
XXI**

317:35-22-2.1 Non-covered services

(a) Services and benefits provided to evaluate and/or treat maternal conditions that are not related to or impact the pregnancy outcome.

(b) ~~Dental.~~

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

SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

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

"Acute Care Hospital" means an institution that meets the requirements defined in Section (§) 440.10 of Title 42 of the Code of Federal Regulations (C.F.R.) and:

(A) ~~is~~Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) ~~is~~Is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) ~~meets~~Meets the requirements for participation in Medicare as a hospital.

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

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"Aged" means an individual whose age is established as sixty-five (65) years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children (AFDC)" means the group of low-income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low-income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for AFDC in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. ~~Effective January 1, 2014, children~~Children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

"Alien" means an individual who does not have United States citizenship and is not a United States national. It is synonymous with the word "noncitizen".

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the Uniform Comprehensive Assessment Tool (UCAT) and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the OHCA.

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the OHCA Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and, when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or **"related"** means the individual meets basic eligibility requirements for an eligibility group.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"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.

"County" means the Oklahoma OKDHS' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by OKDHS.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays eighty percent (80%) of the allowable charge. The remaining twenty percent (20%) is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to

result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Expansion adult" means an individual defined by 42 Code of Federal Regulations (C.F.R.) § 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not related to the aged, blind, or disabled.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the UCAT for the determination of ~~Medical~~ medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Ineligible Spouse" means an individual who is not eligible for Supplemental Security Income (SSI) but is the husband or wife of someone who is receiving SSI.

"Lawfully present" means a noncitizen in the United States who is considered to be in lawful immigration status or class.

"Lawfully residing" means the individual is lawfully present in the United States and also meets Medicaid residency requirements.

"Local office" means the Oklahoma OKDHS' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"MAGI eligibility group" means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 C.F.R. _ 436.603 and listed in OAC 317:35-6-1.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four (4) separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving ~~OASDI~~ Old Age, Survivors, and Disability Insurance (OASDI) or Railroad Retirement income who are age sixty-five (65) or older and for those under age sixty-five (65) who have been receiving disability benefits under these programs for at least twenty-four (24) months.

(i) Persons with end-stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age sixty-five (65) or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a QDWI under Medicaid are

required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of eighteen (18).

"Noncitizen" means an individual who does not have United States citizenship and is not a United States national. It is synonymous with the word "alien".

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IIDs) or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the OKDHS' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the OHCA that assists with the eligibility determination process.

~~**"OKDHS"** means the Oklahoma Department of Human Services.~~ **"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).

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the UCAT for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Reasonably compatible" means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a twelve (12) month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The OHCA Provider Manual (OAC 317:30) contains information

on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ~~ICF/IIDs~~ Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), or inpatient acute care hospital stays are expected to last not less than sixty (60) days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

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

(a) **Citizenship/~~alien~~noncitizen status and identity verification requirements.** Verification of citizenship/~~alien~~noncitizen status and identity ~~are~~ 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~~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 ~~BENDEX~~Beneficiary Earnings and Data Exchange (BENDEX) or ~~SDX~~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 ~~50~~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 ~~ID~~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~~final adoption decree showing the child's name and ~~U.S.~~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~~voter registration card; ~~or~~

(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 ~~16~~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~~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~~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 ~~16~~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 ~~16~~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 citizenship verification.

~~(1) When the applicant/member is unable to obtain citizenship or alienage verification, a reasonable opportunity is afforded to the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded to the applicant/member before taking action affecting the individual's eligibility for SoonerCare. The reasonable opportunity timeframe afforded to SoonerCare members is the same as authorized under Section 1902(ee) of the Social Security Act and is stated on the documentation request the agency sends to the applicant/member. 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 immigration 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 applicant's/member's claim of citizenship;
- (ii) At least one (1) of the individuals making the affidavit cannot be related to the applicant/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) ~~Alienage verification requirements~~ **Noncitizen eligibility.** SoonerCare services are provided as ~~listed~~ 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. ~~Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlement (SAVE).~~

(1) ~~Eligible aliens (qualified aliens).~~ The groups listed in the following subparagraphs are eligible for the full range of SoonerCare services. A qualified alien is:

(A) ~~an alien who was admitted to the United States and has resided in the United States for a period greater than five (5) years from the date of entry and who was:~~

- (i) ~~lawfully admitted for permanent residence under the Immigration and Nationality Act;~~
- (ii) ~~paroled into the United States under Section 212(d)(5) of such Act for a period of at least one (1) year;~~
- (iii) ~~granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or~~
- (iv) ~~a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.~~

(B) ~~an alien who was admitted to the United States and who was:~~

- (i) ~~granted asylum under Section 208 of such Act regardless of the date asylum is granted;~~
- (ii) ~~a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;~~
- (iii) ~~an alien with deportation withheld under Section 243(h) of such Act regardless~~

of the date deportation was withheld;

(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;

(v) an alien who is a veteran as defined in 38 U.S.C. § 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;

(vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;

(vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph;

(viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or

(ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (B) of this paragraph and who later converted to lawful permanent residence status.

(2) Other aliens lawfully admitted for permanent residence (non-qualified aliens). Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for SoonerCare for five (5) years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention, in accordance with 317:30-3-32. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(3) Afghan Special Immigrants. Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are exempt from the five (5) year period of ineligibility for SoonerCare services. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Afghan special immigrants are considered lawful permanent residents.

(4) Iraqi Special Immigrants. Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five (5) year period of ineligibility for SoonerCare services. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Iraqi special immigrants are considered lawful permanent residents.

(5) Undocumented aliens. Undocumented aliens who do not meet any of the definitions in (1) (2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention, in accordance with 30-3-32. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(6) Ineligible aliens.

~~(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for SoonerCare, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.~~

~~(B) These individuals are generally issued Form I-94, Arrival-Departure Record, on which an expiration date is entered. This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record B Parole Edition". Two other forms that do not give the individual "Immigrant" status are Form I-186, Nonresident Alien Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit.~~

~~(d) **Alienage.** A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.~~

~~(1) **Immigrants.** Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the USCIS. These are individuals who entered this country with the express intention of residing here permanently.~~

~~(2) **Parolees.** Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement.~~

~~(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes. These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for SoonerCare if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status:~~

~~(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or~~

~~(B) The following court-ordered notice sent by USCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in Silva vs. Levi, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".~~

~~(4) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered~~

~~the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and, therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the USCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section.~~

~~(5) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half (1/2) American Indian blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least fifty (50) percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.~~

~~(6) **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by USCIS. They are eligible for emergency services only, in accordance with 30-3-32.~~

(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 104–208) 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 104–208);

(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 104-208) 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 104-208);

(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) **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.

(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.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

(1) **Determination of categorical relationship to the disabled by Social Security Administration (SSA).** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for Supplemental Security Income (SSI) on disability.** If the applicant, under age sixty-five (65), states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of twelve (12) months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to

determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, third party query procedure (TPQY) is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received ~~within twelve (12) months from the date of medical services~~timely, per Oklahoma Administrative Code (OAC) 317:30-3-11. After the submission of a timely claim, a claim may be resubmitted, per OAC 317:30-3-11.1. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an

appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two (2) months after hospital release. The details of the verification used are recorded in the case record.

(2) **Determination of categorical relationship to the disabled by the LOCEU.**

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

- (i) have been determined ineligible by SSA on some condition of eligibility other than disability,
- (ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or
- (iii) do not have a disability which would normally be expected to last twelve (12) months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last twelve (12) months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local DHS office is responsible for submitting a medical social summary on DHS form ABCDM-80-D 08MA022E with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and DHS Form 08MA005E are not normally considered pertinent medical information by themselves. Current (less than ninety (90) days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of DHS form 08MA016E, Authorization for Examination and Billing. The DHS worker sends the 08MA016E and DHS form 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(3) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(A) The decision as to whether the applicant is related to Aid to the Disabled.

(B) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(C) A request for additional medical and/or social information when additional information is necessary for a decision.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the Oklahoma Health Care Authority (OHCA) uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/IIDs, or inpatient acute care hospital stays expected to last not less than sixty (60) days. In addition to disability, LOCEU determines the appropriate level of care and cost effectiveness.

(4) **Determination of categorical relationship to the disabled based on Tuberculosis (TB) infection.** Categorical relationship to disability is established for individuals with a diagnosis of TB. An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(5) **Determination of categorical relationship to the disabled for TEFRA.** Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under nineteen (19) years of age, living at home who are disabled as defined by the SSA, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of sixty (60) days), nursing facility or intermediate care facility for individuals with intellectual disabilities, is determined eligible using only his/her income and resources as though he/she were institutionalized.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled

(a) **General.** The term income is defined as a gross gain or gross recurrent benefit that derives from labor, business, property, retirement and other benefits or sources that are available for use on a regular basis.

(1) If it appears the applicant or SoonerCare member is eligible for any type of income ~~(excluding Supplemental Security Income (SSI))~~[excluding Supplemental Security Income (SSI)] or resources, Oklahoma Department of Human Services (OKDHS) staff must notify the individual in writing of his/her potential eligibility, per Section 416.210 of Title 20 of the Code of Federal Regulations (20 C.F.R. § 416.210).

(A) Potential income may include, but is not limited to:

- (i) Retirement, Survivors, Disability Insurance (RSDI) benefits;
- (ii) Benefits from the United States (U.S.) Department of Veterans Affairs (VA);
- (iii) Workers' compensation payments;
- (iv) Unemployment insurance benefits (UIB);
- (v) Annuities;
- (vi) Pensions or other retirement benefits; or
- (vii) Disability benefits.

(B) The notice must contain the information that failure to file for and take all appropriate steps to obtain the potential income within thirty (30) calendar days from the date of the notice will result in an ineligibility determination of ineligibility.

(C) When the individual has a good cause reason for not filing for the potential income within the thirty (30) calendar day period or taking other necessary steps to obtain the income, he or she is not determined ineligible.

(2) If spouses live in their own home, the couple's total income and/or resources are divided equally between the two (2) cases. If they both enter a nursing facility, their income and resources are considered separately.

(3) When an eligible individual or child resides with an ineligible spouse or parent(s), a portion of the ineligible spouse's or parent's income is deemed as available income to the eligible individual, per Oklahoma Administrative Code (OAC) 317:35-5-42(k).

(4) If only one (1) spouse in a couple is eligible and the couple stops living together, only the income and resources that the ineligible spouse actually contributes to the eligible spouse are considered in determining the eligible spouse's eligibility, beginning with the month after the month they stop living together.

(5) Refer to OAC 317:35-9-68 to determine how to consider a community spouse's income eligibility for SoonerCare (Medicaid) when his or her spouse:

- (A) Is institutionalized in a nursing facility or an intermediate care facility for the intellectually disabled;
- (B) Is sixty-five (65) years or older and lives in a mental health hospital; or
- (C) Receives ADvantage or Home and Community Based Waiver services.

(6) In certain circumstances, the amount of income determined to be available to an individual may be greater than the amount of income the individual actually receives for his or her own use. This includes, but is not limited to:

(A) Court-ordered income deductions for child and/or spousal support even when the support is paid directly to the child's guardian or spouse by the individual's employer or benefit payer;

(B) Deductions due to a repayment of an overpayment, loan, or other debt, unless the amount being withheld to reduce a previous overpayment was included when determining the amount of unearned income for a previous month in the determination of medical assistance eligibility; or

(C) Garnishments or liens placed against earned or unearned income of the individual, regardless of the purpose for the garnishment or lien.

(7) The individual's statement regarding the source and amount of available income must be verified at application, renewal, and when changes occur by:

(A) Award letters, warrants, or other documents provided by the individual;

(B) Automated data exchange with other agencies such as Beneficiary and Earnings Data Exchange System (BENDEX); Supplemental Security Income (SSI)/State Data Exchange System (SDX), or UIB;

(C) The Asset Verification System (AVS) when income is held in bank accounts or other financial institutions;

(D) Public records; or

(E) Collateral contacts such as employers, agencies, businesses, or community action groups.

(8) The individual is responsible for reporting and verifying income changes within ten (10) calendar days of the change occurring.

(b) **Sources of income considered.** The individual is responsible for reporting information regarding all sources of available income. All monies or payments that are available for current living expenses, unless specifically disregarded per (c) of this Section are considered in determining monthly gross income. Some of the more common income sources to be considered in determining eligibility are included in (1) through (8) of this subsection:

(1) **Annuities, pensions, retirement, disability, and other payments.** In accordance with 20 C.F.R. § 416.1123, benefits and payments are considered for the month they are received, unless they include retroactive payments. Retroactive payments are considered as lump sum payments per (b)(5) of this Section.

(A) Payments include, but are not limited to:

(i) RSDI and SSI benefits;

(ii) Veteran's benefits;

(iii) Railroad retirement annuities;

(iv) Pensions, retirement, or disability benefits from government or private sources;

(v) Workers' compensation; and

(vi) UIB.

(B) Determination of RSDI benefits to be considered; disregarding cost-of-living adjustments (COLAs) for former State Supplemental Payment recipients, who are reapplying for medical benefits under the Pickle Amendment, are computed, per OKDHS Appendix C-2-A, COLA Increase Computation Formulas.

(C) The U.S. Department of Veterans Affairs allows their recipients to request reimbursement for medical expenses not covered by SoonerCare. When a recipient is eligible for a readjustment payment, it is paid in a lump sum for the entire past year. When received, this reimbursement is disregarded as income or a resource for the

month received. Any amount retained in the month following receipt is considered as a resource.

(D) Government financial assistance in the form of ~~VA~~ Veterans Affairs (VA) Aid and Attendance or Champus payments are considered as:

(i) A third-party resource whether paid to the individual or the facility when the individual resides in a nursing facility. These payments do not affect income eligibility or the vendor payment of the member; or

(ii) Excluded income when paid for an attendant in the individual's home.

(E) SSI benefits may be continued for up to three (3) months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for individuals with an intellectual disability, or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three (3) months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(F) A veteran or his or her surviving spouse who receives a VA pension may have the pension reduced to ninety dollars (\$90) per month if the veteran does not have dependents, is SoonerCare (Medicaid) eligible, and resides in a nursing facility that is approved under SoonerCare, per Section 8003 of Public Law (P.L.) 101-508. The VA pension for a veteran or his or her surviving spouse who meets these conditions is reduced the month following the month of admission to a SoonerCare (Medicaid) approved nursing facility.

(i) The reduced VA pension is not used to compute the vendor payment or spenddown. The nursing facility resident is entitled to receive the ninety-dollars (\$90) reduced VA pension and the regular nursing facility maintenance standard, per OKDHS Appendix C-1, Maximum Income, Resource, and Payment Standards, Schedule VIII.B.2, Maximum Income, Resource, and Payment Standards.

(ii) The vendor payment or spenddown is computed using other income minus the monthly nursing facility maintenance standard and any applicable medical deductions.

(2) **Child support and alimony payments.** Child support and alimony payments are counted as unearned income whether in cash or in-kind. Per (f)(11) of this Section, one-third (1/3) of child support payments received on behalf of the disabled minor child is excluded.

(3) **Dividends, interest, and certain royalties.** Dividends, interest, and certain royalties are counted as unearned income. Dividends and interest are returns on capital investments, such as stocks, bonds, or savings accounts. Royalties are compensation paid to the owner for the use of property or natural resources. Royalties are considered earned income when received as part of the individual's trade or business or in conjunction with a work publication.

(4) **Income from capital resources and rental property.** Income from capital resources may be received from the use of real or personal property, such as land, housing, machinery, leasing of minerals, a life estate, homestead rights, or interest.

(A) Rental income may be treated as self-employment income when the individual participates in the management of the trade or business or invests his/her own labor in producing the income. When the individual does not participate in the management of the trade or business or does not invest his/her own labor in producing the income, it is considered as unearned income.

(i) The individual's federal income tax return or business records verify when the rental income is considered as self-employment income. When the individual's

federal tax return or business records do not verify the rental income is from self-employment, the income is considered unearned income.

(ii) Expenses necessary for the production or collection of the rental income are deducted when paid, not when they are incurred. Examples of deductible expenses include interest on debt, state and local taxes on real or personal property and on motor fuel, general sales taxes, and expenses on managing or maintaining the property. Depreciation or depletion of property is not considered a deductible expense.

(iii) When rental property is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the individual is considered as income.

(B) If the individual receives royalty income monthly but in irregular amounts or less often than monthly, the income is averaged over the previous six (6) month period to determine the countable monthly income.

(i) At any time a dramatic increase or decrease in royalty income occurs, the previous two (2) months of royalty income is averaged to compute the countable monthly income.

(ii) When the difference between the gross and net royalty income is due to a production or severance tax, the net income is used to determine income eligibility as this tax is considered the cost of producing the income.

(5) Lump sum payments. Any income received in a lump sum, with the exception of an SSI or RSDI lump sum, covering a period of more than one (1) month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount retained on the first day of the month following receipt of the lump sum is considered as a resource.

(A) A lump sum payment may be considered as earned or unearned income, depending on the source of the lump sum payment. Lump sum payments may include, but are not limited to:

- (i) Wages or wage bonuses;
- (ii) Retroactive RSDI, VA, or workers' compensation payments;
- (iii) Bonus lease payments;
- (iv) Annual rentals from land or minerals;
- (v) Life insurance death benefits;
- (vi) Lottery or gambling winnings;
- (vii) Personal injury awards or settlements; or
- (viii) Inheritances.

(B) RSDI and SSI retroactive payments do not count as income in the month of receipt. Any unspent portion retained on the first day of the month following receipt of the lump sum is excluded from resources for nine (9) calendar months, per 20 C.F.R. § 416.1233.

However, unspent money from a retroactive payment must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds, but if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount is counted toward the resource limit.

(C) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for children with disabilities or blindness who are under eighteen (18) years of age are excluded as income or a resource. The interest income generated from dedicated bank accounts is also excluded.

(D) A life insurance death benefit received by the individual for another person is considered as income in the month received except for amounts paid for the person's

last illness and burial expenses. Money retained in the month following receipt of the benefit is counted as a resource to the extent that it is available.

(E) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment, all other things being equal.

(6) **Non-negotiable notes and mortgages.** Installment payments received on a note or mortgage are considered as monthly unearned income.

(7) **Income from the Workforce Innovation and Opportunity Act (WIOA).** Unearned income received by an adult, such as a need-based payment, cash assistance, compensation in lieu of wages, or allowances from a program funded by WIOA is considered as any other unearned income.

(8) **In-kind support and maintenance.** In-kind support and maintenance is food or shelter given to the individual or that the individual receives because someone else pays for it. Shelter includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services. The value of this support may be counted as income using the one-third (1/3) reduction rule, per 20 C.F.R. §§ 416.1131 through 416.1133 or the presumed value rule, per 20 C.F.R. §§ 416.1140 through 416.1145.

(A) **One-third (1/3) reduction rule.** The one-third (1/3) reduction rule applies when the individual or the individual and his/her spouse lives in the household of a person who provides him/her with both food and shelter for at least a full calendar month. Per 20 C.F.R. § 416.1131, instead of determining the actual value of in-kind support and maintenance, one-third (1/3) of the SSI federal benefit rate, per OKDHS Appendix C-1, Schedule VIII.C is counted as income.

(i) The one-third (1/3) reduction rule applies in full or not at all. When the individual lives in another person's household and the one-third (1/3) reduction rule applies, no income exclusions are applied to the reduction amount.

(ii) When the one-third (1/3) reduction rule applies and the individual receives other support and maintenance, the other support and maintenance is not counted.

(iii) The one-third (1/3) reduction rule does not apply when the individual or the individual and his/her spouse:

(I) Lives in another person's household but does not receive both food and shelter from that person;

(II) Lives in his/her own household; or

(III) Lives in a non-medical institution such as a public or private non-profit educational or vocational institution, or a private non-profit retirement home.

(B) **Another person's household.** The individual is considered to be living in another person's household if the person is not considered to be living in his/her own home per (C) of this subsection, the person who supplies the support and maintenance lives in the same household, and is not:

(i) The individual's spouse;

(ii) A minor child; or

(iii) An ineligible person whose income may be deemed to the individual per OAC 317:35-5-42(k).

(C) **Living in own household.** The individual or the individual and his/her spouse are considered to be living their own household when:

(i) The individual, the individual and his/her spouse, or a person whose income is deemed to the individual, live in a home in which one of them has an ownership interest or life estate in the home;

(ii) The individual, the individual and his/her spouse, or a person whose income is deemed to the individual is liable for any part of the rent charges;

(iii) The individual pays at least a pro rata share of the household and operating expenses;

(iv) The individual lives in a non-institutional care setting. The individual is considered to be living in a non-institutional care situation when:

- (I) He/she is placed by a public or private agency under a specific program such as foster or family care;
- (II) The placing agency is responsible for the individual's care;
- (III) He/she lives in a private household that is licensed or approved by the placing agency to provide care; and
- (IV) The individual, a public agency, or someone else pays for his/her care; or

(v) All members of the household receive public maintenance payments such as:

- (I) Supplemental Security Income (SSI);
- (II) State Supplemental Payment (SSP);
- (III) Temporary Assistance for Needy Families (TANF);
- (IV) Refugee cash assistance;
- (V) Assistance provided under the Disaster Relief and Emergency Assistance Act;
- (VI) Bureau of Indian Affairs (BIA) general assistance programs;
- (VII) State or local government assistance programs based on need; or
- (VIII) VA payments based on need.

(D) Presumed value rule. The presumed value rule applies when the individual receives in-kind support and maintenance and the one-third (1/3) reduction rule does not apply. The maximum presumed value is one-third (1/3) of the SSI ~~FBR~~ Federal Benefit Rate (FBR), per OKDHS Appendix C-1, Schedule VIII.C plus the ~~\$20~~ twenty dollars (\$20) general income exclusion.

(i) The presumed value rule allows the individual to show that the amount of in-kind support and maintenance is not equal to the maximum presumed value. When the individual does not question the maximum presumed value, one-third (1/3) of the SSI ~~FBR~~ Federal Benefit Rate (FBR), per OKDHS Appendix C-1, Schedule VIII.C plus the ~~\$20~~ twenty dollars (\$20) general income exclusion is counted as unearned income.

(I) When the individual disputes the amount counted for in-kind support and maintenance, he/she may verify that the current market value of the food or shelter he/she receives or the actual amount someone else pays for the individual's food and shelter is lower than the maximum presumed value.

(II) When the individual verifies that the food or shelter received is lower the maximum presumed value, the lower amount is used as the presumed value and counted as unearned income.

(III) When the individual verifies the actual value of the food or shelter he she receives and it is higher than the maximum presumed value amount, the actual amount is counted as unearned income.

(ii) In-kind support and maintenance received by an individual is excluded if:

(I) It is identified as excluded per (e) or (f) of this Section,

(II) It is received from another member of a public assistance household; or

(iii) The individual receives SSI and the SSA does not reduce the individual's SSI benefit because of in-kind support and maintenance.

(iv) When the individual or the individual and his or her spouse live in a household in which all members receive a public maintenance payment per (b)(8)(C)(v) of this subsection, in-kind support and maintenance is not counted unless the individual receives food and shelter from someone outside of the household.

(9) Earned income. Earned income may include:

(A) **Wages.** Wages include the gross income earned for work performed as an employee before deductions, such as taxes, bonds, pensions, union dues, credit union payments, or cafeteria plans are subtracted.

(i) Wages paid in cash may include salaries, commissions, tips, piece-rate payments, longevity payments, bonuses, severance pay, and any other special payments received due to employment.

(ii) Wages paid to uniformed service members include basic pay, some types of special pay, and some allowances. Allowances paid for on-base housing or privatized military housing are considered unearned income in the form of in-kind support and maintenance. Allowances paid for private housing are considered wages.

(iii) Wages paid in-kind may include the value of food, clothing, shelter, or other items provided in lieu of or in conjunction with wages. The cash value of in-kind benefits must be verified by the employer. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered a countable in-kind benefit. Exception: In-kind pay received by a domestic or agricultural worker is considered unearned income.

(iv) Work study received by an individual who is attending school is considered as earned income with appropriate earned income exclusions, per (g) of this Section applied.

(v) Payments received for services performed in a sheltered workshop or work activities center are counted as earned income. Payments for each calendar quarter are averaged to determine monthly income.

(vi) Income received as wages from a program funded by WIOA is counted as any other earned income.

(vii) Earnings received from the Senior Community Service Employment Program under Title V of the Older Americans Act of 1965 as amended and employment positions allocated at the discretion of Governor of Oklahoma are counted as earned income.

(B) **Self-employment income.** Self-employment income is the gross income earned from a trade or business. Self-employment income also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise, such as an exchange of business or labor, the individual's share of profit or loss in any partnership to which he/she belongs, and money received for the sale of whole blood or plasma. Income eligibility is based on the individual's net self-employment income after subtracting business expenses. Refer to (i)(4) of this Section for self-employment income determination procedures.

(c) **What is not income.** Items that are not considered income per 20 C.F.R. § 416.1103 because the individual cannot use them as food or shelter or to obtain food or shelter include, but are not limited to:

(1) Medical care and services, including medical insurance premiums paid directly by anyone on the individual's behalf;

(2) Social services, as follows:

(A) Assistance provided in cash or in-kind under any federal, state, or local government program to provide social services such as vocational rehabilitation or VA aid and attendance services;

(B) In-kind assistance provided under a non-governmental program for social services. This does not include food or shelter;

(C) Cash provided by a non-governmental social services program, except for cash to cover food or shelter, when the cash:

- (i) Is a repayment for program-approved services for which the individual already paid; or
 - (ii) Is a payment restricted to the future purchase of a program-approved service.
- (3) Receipts from the sale, exchange, or replacement of a resource, including cash or an in-kind item provided to replace or repair a resource that was lost, damaged, or stolen;
 - (4) Any amount refunded on income taxes already paid by the individual;
 - (5) Payments made to the individual under a credit life or credit disability insurance policy;
 - (6) Money the individual borrows or receives as repayment of a loan. When the individual borrow money, regardless of use, it is not considered income if a bona fide debt or obligation to pay can be established. Interest the individual receives on money he/she loans someone else is considered income. Criteria to establish a loan as bona fide includes:
 - (A) An acknowledgment of the obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, documentation must show that the loan is bona fide and how the debt amount and date of receipt was verified.
 - (B) The borrower's acknowledgment of obligation to repay, with or without interest, and the lender's verification of the loan are required to indicate that the loan is bona fide when the loan is from a person(s) not in the loan business.
 - (7) Bills paid for the individual by someone else directly to the provider unless it is considered payment for food or shelter;
 - (8) Replacement of income that is lost, destroyed, or stolen, such as receiving a replacement paycheck because the original payment was stolen;
 - (9) Weatherization assistance; or
 - (10) Receipt of certain non-cash items that would be excluded as a non-liquid resource.
- (d) **Income exclusions.** Certain types and amounts of income are excluded in determining the individual's eligibility for SoonerCare. When applying exclusions:
- (1) Unearned income exclusions are applied before applying earned income exclusions;
 - (2) Income excluded by other federal laws per (e) of this Section are excluded first and then unearned income excluded by the Social Security Act per (f) of this Section;
 - (3) Earned income exclusions are then applied in the order listed per (h) of this Section;
 - (4) Income must never reduce income below zero (0);
 - (5) Unused portions of a monthly exclusion must not be carried over for use in a subsequent month;
 - (6) Other than the ~~\$20~~twenty dollars (\$20) general income exclusion, unused unearned income exclusions are not applied to earned income; and
 - (7) Unused earned income exclusions are never applied to unearned income.
- (e) **Income excluded by other federal laws.** Unearned income excluded by federal laws other than the Social Security Act, per the Appendix to Subpart K of Part 416, includes:
- (1) Federal food and nutrition programs, including:
 - (A) The value of Supplemental Nutrition Assistance Program (SNAP) food benefits;
 - (B) U.S. Department of Agriculture food commodities distributed by a private or governmental program;
 - (C) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;
 - (D) Women, infants, and children program (WIC); and
 - (E) Nutrition programs for older Americans;
 - (2) Housing and utility programs including:

(A) Energy assistance provided through the Low-Income Home Energy Program that includes the Energy Crisis Assistance Program;

(B) Housing assistance provided under the:

(i) U.S. Housing Act of 1937;

(ii) National Housing Act;

(iii) Governmental rental or housing subsidies received in-kind or in cash by governmental agencies, such as the Department of Housing and Urban Development (HUD) for rent, mortgage payments, or utilities;

(iv) Title V of the Housing Act of 1949; or

(v) Any payment received under Section 216 of P. L. 91-646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Student financial assistance that includes:

(A) Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under Section 507 of the Higher Education Amendments of 1968 (P. L. 90-575);

(B) Wages, allowances, or reimbursements for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by an eligible individual with disabilities employed in a project under Title VI of the Rehabilitation Act of 1973 as added by 29 U.S.C. § 795(b)(c); and

(C) Student financial assistance received for attendance costs from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under BIA student assistance programs when it is made available for tuition and fees normally assessed to a student carrying the same academic workload, as determined by the institution. This includes costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under Section 14(27) of P. L. 100-50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. § 1087uu);

(4) Native American payments excluded without regard to a specific tribe or group includes:

(A) Indian judgment funds that are held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under P. L. 93-134 as amended by Section 4 of P. L. 97-458 (25 U.S.C. § 1408). Indian judgment funds include interest and investment income accrued while such funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds but does not apply to sales or conversions of initial purchases or to subsequent purchases. This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household;

(B) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under P.L. 98-64 (25 U.S.C. § 117b). Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from countable income under this exclusion. This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household;

(C) Cash distributions and dividends received by an individual Alaska Native or descendant under the Alaska Native Claims Settlement Act Amendments of 1987, P.L. 100-241, (43 U.S.C. § 1626(c)) to the extent that it does not, in the aggregate, exceed two-thousand dollars (\$2,000) per individual each year. This exclusion does not apply in deeming income from sponsors to aliens;

- (D) Up to two-thousand dollars (\$2,000) per year received by Indians that is derived from individual interests in trust or restricted lands under P.L. 103-66, (25 U.S.C. § 1408), as amended;
- (5) Payments made to members of specific Indian tribes and groups. Refer to 20 C.F.R § 416 Subpart K Appendix, Section IV.B for the complete list. Payments to tribes in Oklahoma on this list include:
- (A) Judgement funds distributed per capita to, or held in trust for, members of the Sac and Fox Indian Nation, and the availability of such funds under Section 6 of P. L. 94-189. This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household;
 - (B) Any judgement funds distributed per capita or made available for programs for members of the Delaware Tribe of Indians and the Absentee Delaware Tribe of Western Oklahoma under Section 8 of P. L. 96-318;
 - (C) Any distribution of judgement funds to members of the Wyandotte Nation of Oklahoma under Section 6 of P. L. 97-371;
 - (D) Distributions of judgement funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma, and the Cherokee Band of Shawnee descendants) under Section 7 of P. L. 97-372;
 - (E) Judgement funds distributed per capita or made available for programs for members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana under Section 7 of P. L. 97-376;
 - (F) Judgement funds distributed per capita or made available for any tribal program for members of the Wyandotte Nation of Oklahoma and the Absentee Wyandottes under Section 106 of P. L. 98-602; and
 - (G) Judgement funds distributed per capita, or held in trust, or made available for programs, for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida under Section 8 of P. L. 101-277. This exclusion applies to income of sponsors of aliens only when the alien lives in the sponsor's household;
- (6) Receipts from lands held in trust and:
- (A) Distributed to members of certain Indian tribes under Section 6 of P.L. 94-114, (25 U.S.C. § 459e);
 - (B) Awarded to the Pueblo of Santa Ana and distributed to members of that tribe under Section 6 of P.L. 95-498; and
 - (C) Awarded to the Pueblo of Zia in New Mexico and distributed to members of that tribe under Section 6 of P.L. 95-499;
- (7) Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the federal or state minimum wage. Programs included under CNCS include:
- (A) AmeriCorps programs;
 - (B) The Retired Senior Volunteer Program;
 - (C) The Foster Grandparent Program; and
 - (D) The Senior Companion Program;
- (8) Benefits from State and Community Programs on Aging, per Title III of the Older Americans Act of 1965, as amended by P.L. 114-144, Older Americans Act Reauthorization Act of 2016. Income received from the Senior Community Service Employment Program under Title V of the Older Americans Act as well as employment positions allocated at the discretion of Governor of Oklahoma is counted as earned income;
- (9) Payments made as restitution under the Civil Liberties Act of 1988 to certain individuals of Japanese ancestry who were detained in internment camps during World War II;

(10) Payments made on or after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under P. L. 101-201 and Section 10405 of P.L. 101-239;

(11) Payments made under Section 6 of the Radiation Exposure Compensation Act, P.L. 101-426 for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(12) The value of any ~~child-care~~ childcare provided or arranged under the Child Care and Development Block Grant Act, as amended by Section 8(b) of P.L. 102-586.

(13) Payments made to individuals because of their status as victims of Nazi persecution per P.L. 103-286;

(14) Matching funds and any interest earned on these funds that are deposited into individual development accounts (IDAs), as a demonstration project or TANF-funded, per 42 U.S.C. § 604;

(15) Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, per P.L. 105-78;

(16) Payments made to certain Vietnam or Korea veterans' children with spina bifida, per P.L. 104-204 (38 U.S.C. § 1805(a)) or PL 108-183;

(17) Payments made to the children of women Vietnam veterans who suffer from certain birth defects, per P.L. 106-419 (38 U.S.C. § 1833(c));

(18) Payments of the refundable child tax credit made under Section 24 of the Internal Revenue Code of 1986;

(19) Assistance provided for flood mitigation activities, per Section 1 of P.L. 109-64 (42 U.S.C. § 4031);

(20) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000, per Section 1 of P.L. 106-398 (42 U.S.C. § 7385e); and

(21) The Oklahoma Achieving a Better Life Experience (ABLE) Program, in accordance with OAC 317:35-5-41.9(c)(1) and 26 U.S.C. § 529A. Money deposited into or withdrawn from a qualified ABLE Program account or a qualified ABLE Program account set up in any other state, is excluded as income or a resource when the individual:

(A) Provides documents to verify the account meets exemption criteria;

(B) Verifies money deposited in the account does not exceed the annual federal gift tax exclusion amount per 26 U.S.C. § 2503(b). Any money deposited in the account in the calendar year that is in excess of the annual federal gift tax exclusion amount is considered as countable income in the amount deposited; and

(C) Verifies withdrawals from the account were used to pay qualified disability expenses (QDE). Money withdrawn for reasons other than to pay QDE is considered as income for the month of withdrawal.

(22) Any other income exempted by new or revised federal statutes that are in effect before the Subpart K Appendix is updated.

(f) Unearned income excluded by the Social Security Act. Unearned income excluded by the Social Security Act, per 20 C.F.R. § 416.1124 includes:

(1) Any public agency's refund of taxes on real property or food;

(2) Need-based assistance that is wholly funded by a State or one of its political subdivisions. For purposes of this rule, an Indian tribe is considered a political subdivision of a State. Assistance is based on need when it is provided under a program that uses the individual's income as an eligibility factor. State need-based assistance programs include the SSP program, but not federal/state programs such as TANF;

- (3) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses. This does not include any portion set aside or actually used for food or shelter;
- (4) Food raised by the individual and/or his or her spouse, if it is consumed by the individual or the individual's household;
- (5) Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any federal statute because of a presidentially-declared disaster;
- (6) The first sixty dollars (\$60) of unearned income received in a calendar quarter that is received infrequently or irregularly. Income is considered:
 - (A) To be infrequent when the individual receives it only once during a calendar quarter from a single source and did not receive that type of income in the month preceding or following the month the income was received; and
 - (B) Irregular when the individual cannot reasonably expect to receive it;
- (7) Alaska longevity bonus payments;
- (8) Payments for providing foster care to an ineligible child placed in the individual's home by a public or private nonprofit child placement or ~~child care~~ childcare agency;
- (9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become a part of the separate burial fund;
- (10) Certain support and maintenance assistance as described in 20 C.F.R. § 416.1157 that is certified in writing by the appropriate state agency to be both based on need and:
 - (A) Provided in-kind by a private nonprofit agency; or
 - (B) Provided in cash or in-kind by a:
 - (i) Supplier of home heating oil or gas;
 - (ii) Rate-of-return entity providing home energy; or
 - (iii) A municipal utility providing home energy;
- (11) One-third (1/3) of child support payments received on behalf of the minor child with disabilities;
- (12) The first twenty dollars (\$20) of any unearned income received in a month other than income in the form of in-kind support and maintenance received in the household of another per (b)(8) of this Section and need-based income. Need-based income is a benefit that uses financial need as a factor to determine eligibility. The twenty dollars (\$20) exclusion does not apply to a needs-based benefit that is totally or partially funded by the federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions, such as SSP, is excluded totally from income. When the individual has less than twenty dollars (\$20) of unearned income in a month, the rest of the twenty dollars (\$20) exclusion may be deducted from the individual's countable earned income;
- (13) Any unearned income received and used to fulfill an approved plan to achieve self-support (PASS) for an individual with disabilities or blindness. The Social Security Administration (SSA) approves the plan, the amount of income excluded, and the period of time approved;
- (14) Federal housing assistance provided under:
 - (A) The U.S. Housing Act of 1937;
 - (B) The National Housing Act;
 - (C) Section 101 of the Housing and Urban Development Act of 1965;
 - (D) Title V of the Housing Act of 1949; or
 - (E) Section 202(h) of the Housing Act of 1959;
- (15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement. This exclusion from income applies to interest accrued on or after April 1, 1990;

(16) The value of any commercial transportation ticket among the fifty states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, that is received as a gift and is not converted to cash;

(17) Payments received by an individual from a fund established by a state to aid crime victims;

(18) Relocation assistance provided by a state or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act;

(19) Special pay received from one of the uniformed services, per 37 U.S.C. § 310;

(20) Interest or other earnings on a dedicated account established for an eligible individual under eighteen (18) years of age when past due benefit payments must or may be paid into such an account, per 20 C.F.R. § 416.1247;

(21) Gifts to children under eighteen (18) years of age with life-threatening conditions from an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, provided that:

(A) In-kind gifts not converted to cash; or

(B) Cash gifts do not exceed two-thousand dollars (\$2,000) within a calendar year;

~~(i) Is blind or disabled;~~

~~(ii) Is under twenty-two (22) years of age; and~~

~~(iii) Attends a college, university, or a course of vocational or technical training designed to prepare students for gainful employment;~~

(22) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than Section 1613(a) of the Social Security Act;

(23) AmeriCorps State and National and ~~AmeriCorps~~AmeriCorps National Civilian Community Corps cash or in-kind payments made to participants or on their behalf, such as food, shelter, and clothing allowances;

(24) Any annuity paid by a state to an individual, or his or her spouse, based on the State's determination that the individual is a veteran and is blind, disabled, or aged; and

(25) The first two-thousand dollars (\$2,000) per calendar year received as compensation for participation in clinical trials that meet the criteria, per Section 1612(b)(26) of the Social Security Act.

(g) **Earned income exclusions.** Per 20 C.F.R. § 416.1112, earned income exclusions are applied after the unearned income exclusions, and in the order listed per (1) through (11) of this subsection. Earned income exclusions must not exceed the amount earned and include:

(1) Earned income tax credit and child tax credit payments;

(2) The first ~~\$30~~thirty dollars (\$30) of infrequent or irregular earned income received in a calendar quarter;

(3) The student earned income exclusion (SEIE) up to the SEIE monthly limit, per OKDHS Appendix C-1, Schedule VIII.E is applied to the earned income of a student who:

~~(A) Is blind or disabled;~~

~~(B) Is under twenty-two (22) years of age; and~~

~~(C) Attends a college, university, or a course of vocational or technical training designed to prepare students for gainful employment.~~

(4) Any portion of the twenty (\$20) month general income exclusion that was not excluded from unearned income in the same month;

(5) The first five-hundred dollars (\$500) of the monthly earnings of an individual who is blind, per Section 15 of Title 7 of the Oklahoma Statutes;

(6) Sixty-five dollars (\$65) of earned income in a month. This exclusion is applied once per couple;

(7) The earned income individuals with disabilities who are not blind used to pay impairment-related work expenses, per 20 C.F.R. § 404.1576, including, but not limited to:

- (A) Attendant care services;
- (B) Assistance with personal functions;
- (C) Payments for medical devices;
- (D) Payments for prosthetic devices;
- (E) Payments for work-related equipment;
- (F) Payments for drugs and medical services used to control the impairment; and
- (G) Payments for transportation costs;

(8) One-half (1/2) of any remaining earned income in a month;

(9) Actual work expenses paid by individuals who are blind and under age sixty-five (65) or who receive SSI as a blind person the month before reaching the age of sixty-five (65), such as transportation expenses to and from work and job performance or improvement expenses;

(10) Earned income received and used to fulfill an approved plan to achieve self-support (PASS) for individuals who are blind or disabled and under sixty-five (65) years of age or who are blind and disabled and received SSI as a blind or disabled person for the month before reaching sixty-five (65) years of age. The SSA approves the plan, the amount of income excluded, and the period of time approved; and

(11) Payments made to participants in AmeriCorps State and National and AmeriCorps National Civilian Community Corps (NCCC). These payments may be made in cash or in-kind and may be made directly to the AmeriCorps participant or on the AmeriCorps participant's behalf. These payments include, but are not limited to: living allowance payments, stipends, educational awards, and payments in lieu of educational awards.

~~(A) Earned or unearned exclusions are never reduced below zero;~~

~~(B) Portions of a monthly exclusion cannot be carried over for use in a subsequent month;~~

~~(C) Earned income exclusions are never applied to unearned income;~~

~~(D) Unearned income exclusions are not applied to earned income except for any remaining portion of the \$20 general income exclusion.~~

(h) **Unused exclusions.** Unused:

(1) Earned or unearned exclusions are never reduced below zero (0);

(2) Portions of a monthly exclusion cannot be carried over for use in a subsequent month;

(3) Earned income exclusions are never applied to unearned income; and/or

(4) Unearned income exclusions are not applied to earned income except for any remaining portion of the twenty dollars (\$20) general income exclusion.

(i) **Monthly income determination.** The total gross amount of earned and unearned income available to the eligible individual and eligible or ineligible spouse is determined before subtracting applicable unearned and earned income exclusions per (d) through (g) of this ~~section~~Section. In calculating monthly income, cents are included in the computation until the monthly amount of each income source is established. Once the monthly amount of each income source is established, cents are rounded to the nearest dollar, (one (1) to forty-nine (49) cents is rounded down, and fifty (50) to ninety-nine (99) cents is rounded up).

(1) **Averaging income.** When the individual indicates that he/she receives income monthly, but on an irregular basis, the most recent two (2) months of income are averaged to determine income eligibility.

(A) Income that is received less often than monthly or in amounts that vary significantly over the course of a year may be averaged over a longer period of time. For instance, royalty income must be averaged over a six (6) month period.

(B) Less than two (2) months of income may be used when the income started less than two (2) months ago or previous income amounts are not representative of future income. For instance, the individual may have started a new job less than two (2)

months ago or may have received a one-time bonus or overtime pay that is not expected to recur.

(2) **Converting income to a monthly amount.** Income received more often than monthly is converted to monthly amounts as indicated in (A) through (E) of this subsection:

(A) **Daily.** Income received on a daily basis is converted to a weekly amount. When there is consistency in days worked each week and regular pay dates, the income is multiplied by 4.3. When there is no consistency, refer to (3) of this subsection for irregular income processing.

(B) **Weekly.** Income received weekly is multiplied by 4.3.

(C) **Twice a month.** Income received twice a month is multiplied by two (2).

(D) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.

(E) **Irregular income.** Income received monthly but at irregular intervals is not converted by 4.3, 2, or 2.15 when there is no consistency in the work offered or when pay is received. Instead, the income received over the last two (2) months is added together and divided by two (2) to arrive at a monthly average.

(3) **Infrequent or irregular income.** Infrequent or irregular income is considered countable income in the month it is received unless excluded per (C) of this paragraph.

(A) Income is considered to be infrequent if the individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month preceding or following the month the income was received.

(B) Income is considered to be irregular if the individual cannot reasonably expect to receive it.

(C) When the individual receives infrequent or irregular income, exclude the first:

(i) ~~\$30~~ Thirty dollars (\$30) per calendar quarter of earned income; and

(ii) ~~\$60~~ Sixty dollars (\$60) per calendar quarter of unearned income.

(4) **Self-employment income determination.** Self-employment income is determined per (A) through (E) of this paragraph:

(A) When filed, the federal income tax form for the most recent year is used to calculate the individual's self-employment income and business expenses for the certification period. The net earnings shown on the income tax form after business expenses are subtracted is divided by twelve (12) months to determine the individual's monthly countable self-employment income.

(B) When the individual did not file a federal tax form for the most recent year, the individual's business records showing monthly income and expenses are used to determine the individual's self-employment income. When the business was in operation for the entire year, the individual's net income after subtracting business expenses is divided by twelve (12) months to determine the individual's monthly countable self-employment income.

(C) Self-employment income that represents a household's annual support is prorated over a twelve-month (12-month) period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a twelve-month (12-month) period if the income represents the farmer's annual support.

(D) If the household's business has operated for less than a year, the income from that business is averaged over the period of time the business has operated to establish the monthly income amount.

(E) After the net countable self-employment income is determined, the earned income exclusions per (g) of this section are then applied to establish countable earned income.

(5) **SSI recipients.** If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income does not affect SoonerCare receipt and the State

Supplemental Payment (SSP) payment amount as long as the changed income amount does not cause SSI ineligibility.

(A) Income considered by SSI in the retrospective cycle is not counted until SSI makes the change, so the income is not counted twice. If the SSI change is not made timely by SSA, the income is counted as if it had been timely.

(B) If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare and SSP benefit. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the OKDHS worker becomes aware of income changes that affect the individual's SSI eligibility or payment amount, he/she shares the information with the SSA office.

(j) **Computation of income.** After determining the individual's and his/her spouse's monthly income.

(1) **General income exclusion.** The general income exclusion of twenty dollars (\$20) per month is subtracted from the combined unearned income of the eligible individual and eligible or ineligible spouse, unless the only unearned income is SSP. If any portion of the general income exclusion is not subtracted from unearned income, it is subtracted from earned income.

(2) **Earned income deduction.** When the individual has earned income, after deducting the twenty dollars (\$20) exclusion, the sixty-five (\$65) and one-half of the remaining combined earned income is then deducted.

(3) **Deeming computation procedures.** Refer to OAC 340:35-5-42(k) for deeming computation procedures from an ineligible spouse, ineligible parent, sponsor of an alien or an essential person to the eligible individual or child.

(k) **General income deeming procedures.** The term deeming is used to identify the process for considering another individual's income to be available to the applicant or SoonerCare member, described in this Section as the eligible individual or child. Per Section 416.1160 of Title 20 of the Code of Federal Regulations (20 C.F.R. § 416.1160), there are four (4) categories of individuals whose income may be deemed when determining eligibility: an ineligible spouse, ineligible parent, the sponsor of an alien, or an essential individual. The first step in deeming is determining how much income the applicable individual(s) has. When deeming rules apply, it does not matter if the other individual's income is actually available to the eligible individual or child.

(1) **Ineligible spouse.** An ineligible spouse is a spouse who lives in the same household with the eligible individual and is not eligible for Supplemental Security Income (SSI). For spouse-to-spouse deeming to apply, the eligible individual must be eligible based on his or her own income.

(2) **Ineligible parent.** An ineligible parent is a natural or adoptive parent or stepparent who lives with an eligible child under eighteen (18) years of age and is not eligible for SSI. A stepparent's income is not deemed if the eligible child's natural or adoptive parent dies or permanently leaves the home, per 20 C.F.R. § 416.1165.

(3) **Sponsor of an alien.** A sponsor is an individual, not an organization or an employer, who signs an affidavit agreeing to support the alien as a condition for the alien's admission for permanent residence in the ~~United States (U.S.)~~ U.S. A portion of the sponsor's income is deemed to the alien for three (3) years even when the sponsor and alien do not live together unless (A) if this paragraph applies.

(A) Deeming rules regarding sponsored aliens do not apply when the alien:

(i) Is a refugee admitted to the ~~United States (U.S.)~~ U.S., per Section 203(a)(7), 207(c)(1) or Section 212(d)(5) the Immigration and Nationality Act;

(ii) Was granted asylum by the Attorney General of the U. S.; or

(iii) Becomes blind or disabled, per 20 C.F.R §_416.901 after admission to the U. S.
When this occurs, the sponsor's income is no longer deemed beginning with the month in which you're the disability or blindness begins.

(B) If the sponsor is the alien's ineligible spouse or ineligible parent(s), the spouse-to-spouse or parent-to-child deeming calculations apply.

(C) If a sponsored alien has a sponsor and an ineligible spouse or ineligible parent(s) who is not his/her sponsor, both sponsor-to-alien and spouse-to-spouse or parent-to-child deeming calculations apply.

(4) **Household definition.** A household for deeming purposes may include the eligible individual or child, an eligible or ineligible spouse, and any children of the couple or of either member of the couple. A household for an eligible child includes the eligible child's parent(s), and any other children of the parent(s).

(A) A child is considered a member of the household from birth for deeming purposes unless the parent(s) completed paperwork to give the child up for adoption or the child was placed in the temporary custody of a public children's services agency. Exception: A premature infant born at thirty-seven (37) weeks or less whose birth weight is less than two (2) pounds ten (10) ounces is considered disabled by the ~~Social Security Administration~~ SSA even if no other medical impairment exists. When this occurs, the parent(s)' income is not deemed to the child until the month after the month the child leaves the hospital and begins living with his/her parent(s).

(B) An eligible individual or an ineligible spouse or ineligible parent who is temporarily absent from the home per (5) of this subsection, is considered to be a member of the household for deeming purposes per 20 C.F.R. § 416.1167.

(5) **Temporary absence for deeming purposes.** During a temporary absence, per 20 C.F.R. § 416.1167, the absent individual is considered a household member for deeming purposes when an:

(A) Eligible individual or child, ineligible spouse, ineligible parent, or an ineligible child leaves the household but intends to and does return in the same month or the next month;

(B) Eligible individual or child enters a medical treatment facility for up to two (2) or three (3) full months;

(C) Eligible child is away at school but comes home on some weekends or lengthy holidays and is subject to his/her parent's control; or

(D) Ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the Armed Forces on active duty.

(1) **Income exclusions for an ineligible spouse or ineligible parent.** Income excluded for an ineligible spouse or parent per 20 C.F.R. § 416.1161 include:

(1) Income excluded by federal laws other than the Social Security Act, per the Appendix to Subpart K of Part 416 and Oklahoma Administrative Code (OAC) 317:35-5-42(e);

(2) Any public income-maintenance payments the ineligible spouse or parent receives and any income that was counted or excluded in figuring the amount of that payment. Per 20 C.F.R § 416.1142, these payments include SSI, State Supplemental Payment (SSP), TANF, refugee cash assistance, disaster relief and emergency assistance, general assistance provided by the Bureau of Indian Affairs, and U.S. Department of ~~Veteran~~ Veterans Affairs, State or local government assistance programs based on need;

(3) Any of the ineligible spouse's or parent's income that is used by a public income-maintenance program to determine that program's benefits to someone else;

(4) Income used to comply with the terms of court-ordered support, or support payments enforced under Title IV-D of the Social Security Act;

- (5) Income the ineligible spouse or ineligible parent was paid under a federal, state, or local government program to provide the eligible spouse or child with chore, attendant, or homemaker services, such as payments under Title XX of the Social Security Act;
- (6) Any portion of a grant, scholarship, fellowship, or gift used or set aside to pay tuition, fees or other necessary educational expenses;
- (7) Money received for providing foster care to an ineligible child;
- (8) The value of Supplemental Nutrition Assistance Program food benefits and the value of Department of Agriculture donated foods;
- (9) Food raised by the spouse or parent and consumed by members of the household in which you live;
- (10) Tax refunds on income, real property, or food purchased by the family;
- (11) Income used to fulfill an approved plan for achieving self-support, per 20 C.F.R. §§ 416.1180 through 416.1182 and OAC 317:35-5-42(f)(13) and (g)(10);
- (12) The value of in-kind support and maintenance as described in OAC 317:35-5-42(b)(8);
- (13) Alaska longevity bonus payments;
- (14) Disaster assistance, per 20 C.F.R. §§ 416.1150 and 416.1151;
- (15) Income received infrequently or irregularly, per 20 C.F.R. §§ 416.1112(c)(1) and 416.1124(c)(6) and OAC 317:35-5-42(f)(6) and (g)(2);
- (16) Work expenses if the ineligible spouse or parent is blind such as transportation expenses to and from work and job performance or improvement expenses;
- (17) Certain support and maintenance assistance, per 20 C.F.R. § 416.1157(c) and OAC 317:35-5-42(e)(10);
- (18) Housing assistance, per 20 C.F.R. § 416.1124(c)(14);
- (19) The value of a commercial transportation ticket, per 20 C.F.R. § 416.1124(c)(16). However, if such a ticket is converted to cash, the cash is income in the month your spouse or parent receives the cash;
- (20) Refunds of ~~Federal~~federal income taxes and advances made by an employer relating to an earned income tax credit, per 20 C.F.R. § 416.1112(c);
- (21) Payments from a fund established by a State to aid victims of crime, per 20 C.F.R. § 416.1124(c)(17));
- (22) Relocation assistance, per 20 C.F.R. § 416.1124(c)(18);
- (23) Special pay received from one of the uniformed services pursuant to Section 310 of Title 37 of the United States Code;
- (24) Impairment-related work expenses, per 20 C.F.R. § 404.1576 and OAC 317:35-5-42(g)(7), incurred and paid by an ineligible spouse or parent, if the ineligible spouse or parent receives disability benefits under Title II of the Social Security Act;
- (25) Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which are left to accumulate and become part of separate burial funds, and interest accrued on and left to accumulate as part of the value of agreements representing the purchase of excluded burial spaces per 20 C.F.R. § 416.1124(c)(9) and (15));
- (26) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than Section 1613(a) of the Social Security Act;
- (27) Earned income of a student, per 20 C.F.R. § 416.1112(c)(3) and OAC 317:35-5-42(g)(3); and
- ~~(28) Any additional increment in pay, other than any increase in basic pay, received while serving as a member of the uniformed services, if the ineligible spouse or parent:~~
- (28) Any additional increment in pay, other than any increase in basic pay, received while serving as a member of the uniformed services, if the ineligible spouse or parent:
 - (A) Received the pay as a result of deployment to or service in a combat zone; and

(B) Was not receiving the additional pay immediately prior to deployment to or service in a combat zone.

(m) **Deeming from an ineligible spouse.** When the eligible individual lives with an ineligible spouse who has income, the deeming steps in (1) through (5) of this paragraph are used to calculate the amount of income to deem to the eligible individual.

(1) The ineligible's spouse's total gross unearned and earned income is determined and appropriate exclusions per (l) of this Section are applied.

(2) An ineligible child allocation is then subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Maximum Income, Resource, and Payment Standards, Schedule VIII.C.

(A) The ineligible child allocation is subtracted from the ineligible spouse's unearned income before subtracting any remaining allocation from his/her earned income.

(B) An ineligible child allocation is not allowed for a child who receives a public income-maintenance ~~payments~~ payment, per 20 C.F.R. § 416.1142 and as listed per (l)(2) of this Section.

(C) When the ineligible child has countable income, the child's income is subtracted from the ineligible child allocation before subtracting the remaining allocation from the ineligible spouse's income.

(3) When the ineligible spouse sponsors an alien(s), the allocation for the alien(s) that is deemed from the ineligible spouse's income is subtracted from the ineligible spouse's unearned income before subtracting any remaining allocation from his/her earned income.

(A) The allocation for each sponsored alien is the difference between the SSI ~~federal benefit rate (FBR)~~ FBR for an eligible couple minus the FBR for an eligible individual, per OKDHS Appendix C-1, Schedule VIII.C.

(B) Each alien's allocation is reduced by the amount of the alien's own income, per (m) of this Section.

(4) When, after subtracting the ineligible child allocation and, if appropriate, the sponsored alien allocation, the ineligible spouse's income is less than or equal to the difference between the SSI FBR for an eligible couple and the SSI FBR for an eligible individual, per OKDHS Appendix C-1, Schedule VIII.C, no income is deemed from the ineligible spouse.

(A) In this instance, only the eligible individual's own countable income minus exclusions per (l) of this Section is considered.

(B) When the eligible individual's countable income is less than or equal to the SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, he/she is financially eligible for SoonerCare (Medicaid). When the eligible individual's countable income is over the SSI FBR standard, the individual's eligibility for Qualified Medicare Beneficiary Plus (QMBP) must still be evaluated.

(5) When, after subtracting the appropriate allocations, the ineligible spouse's income is greater than the difference between the SSI FBR for an eligible couple and the SSI FBR for an eligible individual, per OKDHS Appendix C-1, Schedule VIII.C, the spouses are treated as an eligible couple by:

(A) Combining the remainder of the ineligible spouse's unearned income with the eligible individual's unearned income and the remainder of the ineligible spouse's earned income with the eligible individual's earned income;

(B) Applying appropriate income exclusions, per OAC 317:35-5-42(e), (f), and (g) from the eligible spouse's income, including the ~~\$20~~ twenty dollars (\$20) general exclusion from the couple's unearned income and ~~\$65~~ sixty-five dollars (\$65) plus one-half (1/2) of the remaining earned income from the couple's earned income; and

(C) Subtracting the couple's countable income from the SSI FBR for an eligible couple, per OKDHS Appendix C-1, Schedule VIII.C. When the income is less than or equal to

the SSI FBR for an eligible couple, the eligible individual is financially eligible for SoonerCare (Medicaid). When the eligible individual's countable income is over the SSI FBR standard, the individual's eligibility for Qualified Medicare Beneficiary Plus (QMBP) must still be evaluated.

(n) **Deeming from ineligible parent(s).** When a child with disabilities or blindness lives with ineligible parent(s), the deeming steps in (1) through (6) of this paragraph are used to calculate the amount of income to deem to the eligible child, up through the month in which the child reaches age eighteen (18).

(1) The gross unearned and earned income of each ineligible parent living in the home is determined and appropriate exclusions are applied, per (l) of this Section.

(2) An ineligible child allocation is subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Schedule VIII.C. Exception: An ineligible child allocation is not allowed for a child who receives public income-maintenance payments, per 20 C.F.R. § 416.1142 and as listed per (l)(2) of this Section.

(A) The ineligible child allocation is first subtracted from the ineligible parent(s)' combined unearned income before subtracting any remaining allocation from their earned income.

(B) When the ineligible child has countable income, the child's income is subtracted from the ineligible child allocation before applying the allocation.

(3) When the ineligible parent sponsors an alien(s), the allocation for the alien(s) that is deemed from the ineligible parent's income per (p) of this Section is subtracted from the ineligible parent(s)' income.

(4) An allocation is then subtracted for the ineligible parent(s) unless the parent receives public income-maintained payments. The allocation is calculated by:

(A) Subtracting the twenty dollars (\$20) general exclusion from the combined unearned income of the ineligible parent(s). If there is less than twenty dollars (\$20) of unearned income, subtract the twenty dollars (\$20) remaining exclusion from their combined earned income;

(B) Subtracting sixty-five dollars (\$65) and one-half of the remainder of their earned income; and

(C) Totaling the ineligible parent(s)' remaining earned and unearned income and, depending on the number of parents in the home, subtracting the SSI FBR for an individual or a couple, per OKDHS Appendix C-1, Schedule VIII.C.

(5) The parent(s)' remaining income is then deemed to the eligible child. When there is more than one (1) eligible child in the home, the parent(s)' remaining income is divided by the number of eligible children in the home.

(6) The deemed income is added to the eligible child's own countable unearned income. When the eligible child's deemed and own unearned and earned income, minus appropriate exclusions, per OAC 317:35-5-42(e),(f), and (g), is less than or equal to the SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, the child is financially eligible for SoonerCare (Medicaid).

(A) When a child with intellectual disabilities is ineligible for SoonerCare due to the deeming process, he/she may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program, per OAC 317:35-9-5.

(B) When a child is eligible for Tax Equity & Fiscal Responsibility Act (TEFRA), the income of child's parent(s) is not deemed to him/her.

(C) The parent(s)' income is not deemed to a premature infant born at thirty-seven (37) weeks or less whose birth weight is less than twelve hundred (1200) grams or approximately two (2) pounds ten (10) ounces until the child leaves the hospital and begins living with his/her parent(s).

(o) Deeming when the household includes an ineligible spouse, an eligible spouse, and an eligible and ineligible child. When the household includes an ineligible spouse, an eligible spouse, one or more eligible children, and one or more ineligible children, the ineligible spouse's income is first deemed to the eligible spouse and the remainder to the eligible child(ren) using the deeming steps in (1) through (6) of this subsection.

(1) The gross unearned and earned income of the ineligible spouse is determined and appropriate exclusions are applied, per (l) of this Section.

(2) An ineligible child allocation is subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Schedule VIII.C. Exception: An ineligible child allocation is not allowed for a child who receives public income-maintenance payments, per 20 C.F.R. § 416.1142 and as listed per (l)(2) of this Section.

(3) If the ineligible spouse's remaining income is less than or equal to the current SSI FBR for a couple minus the current SSI FBR for an individual, no income is deemed to the eligible spouse or eligible child(ren).

(A) Compare the eligible spouse's and each eligible child's own countable income, after applying appropriate exclusions, per OAC 317:35-5-42(e),(f), and (g) to the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C.

(B) When the eligible spouse's and/or each eligible child's own income is less than or equal to the current SSI FBR for an individual, they are financially eligible for SoonerCare.

(4) If the ineligible spouse's remaining income after subtracting the ineligible child allocation(s) is greater than the current SSI FBR for a couple minus the current SSI FBR for an individual:

(A) Combine the ineligible spouse's post-allocation unearned and earned income and the eligible spouse's unearned and earned income, after applying the appropriate exclusions, per OAC 317:35-5-42(e),(f), and (g);

(B) Subtract the twenty dollars (\$20) general exclusion from the couple's combined unearned income. If there is less than twenty dollars (\$20) of unearned income, then subtract the remainder of the exclusion from the couple's combined earned income; and

(C) Subtract sixty-five dollars (\$65) plus one-half of the remainder from the couple's combined earned income.

(5) If the couple's countable income is less than or equal to the current SSI FBR for a couple, per OKDHS Appendix C-1, Schedule VIII.C, the eligible spouse is financially eligible for SoonerCare and no income is deemed to the eligible child(ren). If the couple's countable income is greater than the current SSI FBR for a couple, the eligible spouse is not financially eligible for SoonerCare.

(6) When the eligible spouse is not financially eligible for SoonerCare, the amount of the couple's income in excess of the SSI FBR for a couple is divided by the number of eligible children in the household. The resulting amount is deemed to each eligible child.

(A) Any income deemed to an eligible child is added to the eligible child's own unearned income.

(B) The eligible child's unearned and earned income are combined after applying appropriate exclusions, per OAC 317:35-5-42(e),(f), and (g).

(C) If each eligible child's resulting countable income is less than or equal to the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, the eligible child is financially eligible for SoonerCare.

(p) Deeming from a sponsor to an alien. Sponsor-to-alien deeming applies regardless of whether the sponsor and the sponsored alien live in the same household or whether the sponsor actually provides any support to the sponsored alien unless (a)(3)(A) applies.

- (1) The income of the sponsor and the sponsor's spouse, if applicable, is first determined and applicable exclusions applied, per OAC 317:35-5-42(e).
- (2) The appropriate allocation for the sponsor, the sponsor's spouse, and any children of the sponsor is then subtracted. An ineligible dependent's income is not subtracted from the sponsor's child(ren)'s allocation.
 - (A) The allocation amount for the sponsor is the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C.
 - (B) The allocation for each sponsor's spouse and child(ren) of each sponsor is one-half of the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C.
- (3) The remaining income amount is deemed to the sponsored alien as unearned income. If the sponsor sponsors multiple aliens, the deemed amount is applied in full to each sponsored alien.
- (4) The sponsored alien's unearned and earned income is combined and applicable exclusions applied, per OAC 317:35-5-42(e),(f), and (g). When the alien's countable income and deemed income is less than or equal to the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, the alien is financially eligible for SoonerCare.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.1. Outpatient hospital services

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to the Oklahoma Health Care Authority (OHCA) contracted, non-hospital providers performing the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

(b) Covered outpatient hospital services must meet ~~all~~of all the criteria listed in (1) through (4) of this subsection.

(1) The care is directed by a physician or dentist.

(2) The care is medically necessary.

(3) The member is not an inpatient [refer to Oklahoma Administrative Code (OAC) 317:30-5-41].

(4) The service is provided in an approved hospital facility.

(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).

(d) In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(e) Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(f) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital-based setting. Coverage is limited to one (1) evaluation/re-evaluation visit (unit) per discipline per calendar year and fifteen (15) visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).

(g) Diabetes self-management education and support (DSMES) services are provided to members diagnosed with diabetes. DSMES services are comprised of one (1) hour of individual instruction (face-to-face encounters between the diabetes educator and the member) and nine (9) hours of group instruction on diabetes self-management. Members shall receive up to ten (10) hours of services during the first twelve (12) month period beginning with the initial training date. After the first twelve (12) month period has ended, members shall only be eligible for two (2) hours of individual instruction on DSMES per calendar year. Refer to OAC 317:30-5-1080 through 317:30-5-1084 for specific provider and program requirements, and reimbursement methodology.

(h) For high-investment drugs, refer to OAC 317:30-5-42.20.

(i) For partial hospitalization program services for adults and children, refer to OAC 317:30-5-241.2.2 and 317:30-5-241.2.3.

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.2. Psychotherapy

(a) **Psychotherapy-Individual psychotherapy.**

(1) **Definition.** Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse, or change maladaptive patterns of behavior, and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. The therapy must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(2) **Interactive Complexitycomplexity.** Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the qualified practitioner. Sessions typically involve members who have other individuals legally responsible for their care (i.e., minors or adults with guardians); members who request others to be involved in their care during the session (i.e., adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e., child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one (1) of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e., related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the service plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter, or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified practitioners.** Psychotherapy must be provided by a ~~licensed behavioral health professional (LBHP)~~an LBHP or licensure candidate in a setting that protects and assures confidentiality.

(4) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

~~(4)(5)~~ **Limitations.** A maximum of four (4) units per day per member is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the qualified practitioner should be present during the session. ~~Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.~~ Individual psychotherapy is not reimbursable for a child younger than the age of thirty-six (36) months. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(b) **Group Psychotherapypsychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the qualified practitioner and two (2) or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under ~~Behavioral Health Rehabilitation Services~~behavioral health rehabilitation services.

(2) **Group sizes.** Group ~~Psychotherapy~~psychotherapy is limited to a total of eight (8) adult [eighteen (18) and over] individuals except when the individuals are residents of an ICF/IID where the maximum group size is six (6). For all children under the age of eighteen (18), the total group size is limited to six (6).

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight (8) families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified practitioners.** Group psychotherapy ~~will~~must be provided by an LBHP or licensure candidate. Group ~~Psychotherapy~~psychotherapy must take place in a confidential setting limited to the qualified practitioner, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) Documentation requirements. Providers must comply with documentation requirements in OAC 317:30-5-248.

~~(5)~~(6) Limitations. A maximum of six (6) units per day per member is compensable, not to exceed twelve (12) units per week. Group ~~Psychotherapy~~psychotherapy is not reimbursable for a child younger than the age of ~~three (3)~~thirty-six (36) months. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(c) **Family ~~Psychotherapy~~psychotherapy.**

(1) **Definition.** Family ~~Psychotherapy~~psychotherapy is a face-to-face psychotherapeutic interaction between a qualified practitioner and the member's family, guardian, and/or support system. It is typically inclusive of the identified member; but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the ~~Evidence Based Practice titled Family Psychoeducation~~evidence-based practice "Family Psychoeducation". For children under the age of thirty-six (36) months, family psychotherapy is focused on the infant/young child and parent (or primary caregiver) interactions and the relationship needs of the infant/young child.

(2) **Qualified practitioners.** Family ~~Psychotherapy~~psychotherapy must be provided by an LBHP or licensure candidate.

(3) Documentation requirements. Providers must comply with documentation requirements in OAC 317:30-5-248.

~~(3)~~(4) Limitations. A maximum of four (4) units per day per member/family unit is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. ~~The practitioner may not bill any time associated with note taking and/or medical record upkeep. The practitioner may only bill the time spent in direct face to face contact. Practitioner must comply with documentation requirements listed in OAC 317:30-5-248.~~ Family psychotherapy for a child younger than thirty-six (36) months must be medically necessary and meet established child [zero (0) through

thirty-six (36) months of age] criteria as set forth in the Prior Authorization Manual. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(d) Multi-Systemic Therapy (MST).

~~(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.~~

~~(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.~~

~~(3) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.~~

~~(4) **Service limitations.** Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than eight (8) minutes.~~

(e) Children/Adolescent Partial Hospitalization Program (PHP).

~~(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:~~

~~(A) Assessment, diagnostic and service plan services for mental illness and/or substance use disorders provided by LBHPs or licensure candidates.~~

~~(B) Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs or licensure candidates.~~

~~(C) Substance use disorder specific services are provided by LBHPs or licensure candidates qualified to provide these services.~~

~~(D) Drugs and biologicals furnished for therapeutic purposes.~~

~~(E) Family counseling, the primary purpose of which is treatment of the member's condition.~~

~~(F) Behavioral health rehabilitation services to the extent the activities are closely and clearly related to the member's care and treatment, provided by a Certified Behavioral Health Case Manager II, Certified Alcohol and Drug Counselor (CADC), LBHP, or licensure candidate who meets the professional requirements listed in OAC 317:30-5-240.3.~~

~~(G) Care Coordination of behavioral health services provided by certified behavioral health case managers.~~

~~(2) **Qualified practitioners.**~~

~~(A) All services in the PHP are provided by a clinical team, consisting of the following required professionals:~~

~~(i) A licensed physician;~~

~~(ii) Registered nurse; and~~

~~(iii) One or more of the licensed behavioral health professionals (LBHP) or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).~~

~~(B) The clinical team may also include a Certified Behavioral Health Case Manager.~~

~~(C) The service plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program.~~

~~(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.~~

~~(4) **Limitations.** Services are limited to children 0-20 only. Children under age six (6) are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages four (4) and five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity. Services must be offered at a minimum of three (3) hours per day, five (5) days per week. Therapeutic services are limited to four (4) billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Group size is limited to a maximum of eight (8) individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.~~

~~(5) **Service requirements.**~~

~~(A) Therapeutic Services are to include the following:~~

~~(i) Psychiatrist/physician face to face visit two (2) times per month;~~

~~(ii) Crisis management services available twenty four (24) hours a day, seven (7) days a week;~~

~~(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:~~

~~(i) Individual therapy—a minimum of one (1) session per week;~~

~~(ii) Family therapy—a minimum of one (1) session per week; and~~

~~(iii) Group therapy—a minimum of two (2) sessions per week;~~

~~(C) Interchangeable services which include the following:~~

~~(i) Behavioral Health Case Management (face to face);~~

~~(ii) Behavioral health rehabilitation services/alcohol and other drug abuse education except for children under age six (6), unless a prior authorization has been granted for children ages four (4) and five (5);~~

~~(iii) Medication Training and Support; and~~

~~(iv) Expressive therapy.~~

~~(6) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within twenty four (24) hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to OAC 317:30-5-248.~~

~~(7) **Staffing requirements.** Staffing requirements must consist of the following:~~

~~(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care [one (1) RN at a minimum can be backed up by an LPN but an RN must always be onsite]. Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.~~

~~(B) Medical director must be a licensed psychiatrist.~~

~~(C) A psychiatrist/physician must be available twenty four (24) hours a day, seven (7) days a week.~~

(f) Children/Adolescent Day Treatment Program.

~~(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.~~

~~(2) **Qualified practitioners.** All services in Day Treatment are provided by a team, which must be composed of one (1) or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP) or licensure candidate, a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Services are directed by an LBHP or licensure candidate.~~

~~(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited to provide Day Treatment services by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA).~~

~~(4) **Limitations.** Services must be offered at a minimum of four (4) days per week at least three (3) hours per day. Behavioral Health Rehabilitation Group size is limited to a maximum of eight (8) individuals as clinically appropriate given diagnostic and developmental functioning. Children under age six (6) are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages four (4) and five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity.~~

~~(5) **Service requirements.** On-call crisis intervention services must be available twenty four (24) hours a day, seven (7) days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist twenty four (24) hours a day, seven (7) days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.~~

~~(A) Treatment activities are to include the following every week:~~

- ~~(i) Family therapy at least one (1) hour per week (additional hours of FT may be substituted for other day treatment services);~~
- ~~(ii) Group therapy at least two (2) hours per week; and~~
- ~~(iii) Individual therapy at least one (1) hour per week.~~

~~(B) Additional services are to include at least one (1) of the following services per day:~~

- ~~(i) Medication training and support (nursing) once monthly if on medications;~~
- ~~(ii) Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in OAC 317:30-5-241.3 and is clinically necessary and appropriate except for children under age six (6), unless a prior authorization has been granted for children ages four (4) and five (5);~~
- ~~(iii) Behavioral health case management as needed and part of weekly hours for member;~~
- ~~(iv) Occupational therapy as needed and part of weekly hours for member; and~~
- ~~(v) Expressive therapy as needed and part of weekly hours for the member.~~

~~(6) **Documentation requirements.** Service plans are required every three (3) months.~~

317:30-5-241.2.1 Multi-systemic therapy (MST)

MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Caseloads are kept low due to the intensity of the services provided.

(1) **Qualified professionals.** All MST services are provided by LBHPs or licensure candidates. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Additional team support services may be provided by a behavioral health case manager II (CM II) and/or peer recovery support specialist (PRSS) per OAC 317:30-5-240.3.

(2) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(3) **Limitations.** Services are subject to the following:

(A) Partial billing is not allowed. When only one (1) service is provided in a day, providers should not bill for services performed for less than eight (8) minutes.

(B) MST cannot be billed in conjunction with the following:

(i) Children's psychosocial rehabilitation;

(ii) Partial hospitalization/intensive outpatient treatment;

(iii) Targeted case management;

(iv) Individual, family, and group therapy;

(v) Mobile crisis intervention;

(vi) Peer-to-peer services.

(C) Duration of MST services is between three (3) to six (6) months. Weekly interventions may range from three (3) to twenty (20) hours per week. Weekly hours may be lessened as case nears closure.

(4) **Reimbursement.** MST services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

317:30-5-241.2.2 Partial hospitalization program (PHP) - Children/Adolescent

(a) **Definition.** Partial hospitalization is an intermediary, stabilizing step for children and adolescents who have had inpatient psychiatric hospitalization prior to returning to school and community supports or as a less restrictive alternative when inpatient treatment may not be indicated. PHP services are:

(1) Reasonable and necessary for the diagnosis or active treatment of the member's condition; and

(2) Reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization.

(b) **Eligibility criteria.** This service must be prior authorized by OHCA or its designated agent, and individuals must meet ongoing medical necessity criteria. Treatment is time limited, and length of participation is based on the individual's needs.

(c) **Eligible providers.** Provider agencies for PHP must be accredited to provide partial hospitalization services by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency. The agency is responsible for ensuring that all services are provided by properly credentialed clinicians.

(d) **Qualified practitioners.** Program services are overseen by a psychiatrist. The number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program. The clinical team includes the following required professionals:

- (1) A licensed physician, physician's assistant, or advanced practice registered nurse [any of whom meet the requirements of an LBHP as described at OAC 317:30-5-240.3(a)];
- (2) Registered nurse; and
- (3) One (1) or more LBHPs or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).
- (4) The clinical team may also include a certified behavioral health case manager.

(e) **Service components.** PHP includes the following services:

- (1) Assessment, diagnostic and service plan services for mental illness and/or substance use disorders provided by LBHPs or licensure candidates;
- (2) Individual/group/family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs or licensure candidates;
- (3) Substance use disorder specific services are provided by LBHPs or licensure candidates qualified to provide these services;
- (4) Drugs and biologicals furnished for therapeutic purposes;
- (5) Family counseling, the primary purpose of which is treatment of the member's condition;
- (6) Behavioral health rehabilitation services to the extent the activities are closely and clearly related to the member's care and treatment, provided by a certified behavioral health case manager II, certified alcohol and drug counselor (CADC), LBHP, or licensure candidate who meets the professional requirements listed in OAC 317:30-5-240.3; and
- (7) Care coordination of behavioral health services provided by certified behavioral health case managers.

(f) **Limitations.** Services are subject to the following:

- (1) Children under age six (6) are not eligible for behavioral health rehabilitation services unless a prior authorization for children ages four (4) and five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity.
- (2) Services must be offered at a minimum of three (3) hours per day, five (5) days per week.
- (3) Therapeutic services are limited to four (4) billable hours per day.
- (4) Group size is limited to a maximum of eight (8) individuals as clinically appropriate given diagnostic and developmental functioning.
- (5) Occupational, physical and speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.
- (6) PHP services cannot be billed in conjunction with the following:
 - (A) Children's psychosocial rehabilitation services;
 - (B) Residential services [psychiatric residential treatment facility (PRTF) or residential behavior management services (RBMS)];
 - (C) Targeted case management (TCM);
 - (D) Individual, family, or group therapy;
 - (E) Mobile crisis intervention within the PHP setting;
 - (F) Peer-to-peer services;
 - (G) Certified Community Behavioral Health (CCBH) services;
 - (H) Day treatment;
 - (I) Multi-systemic therapy (MST);
 - (J) Program of Assertive Community Treatment (PACT) [Applicable for individuals eighteen (18) to twenty-one (21) years of age].

(g) **Service requirements.** This service includes:

- (1) Therapeutic services that include the following:
 - (A) Psychiatrist/physician face-to-face visit two (2) times per month; and
 - (B) Crisis management services available twenty-four (24) hours a day, seven (7) days a week.
- (2) Psychotherapies that are provided at a minimum of four (4) hours per week and include the following:
 - (A) Individual therapy - a minimum of one (1) session per week;
 - (B) Family therapy - a minimum of one (1) session per week; and
 - (C) Group therapy - a minimum of two (2) sessions per week.
- (3) Interchangeable services that include the following:
 - (A) Behavioral health case management (face-to-face);
 - (B) Behavioral health rehabilitation services/alcohol and other drug abuse education, except for children under age six (6), unless a prior authorization has been granted for children ages four (4) and five (5);
 - (C) Medication training and support; and
 - (D) Expressive therapy.

(h) Documentation requirements. Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within twenty-four (24) hours of admission. A physical examination and medical history must be coordinated with the primary care physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to OAC 317:30-5-248.

(i) Staffing requirements. Staffing must consist of the following:

- (1) A registered nurse (RN) trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available on-site during program hours to provide necessary nursing care and/or psychiatric nursing care [one (1) RN at a minimum can be backed up by a licensed practical nurse (LPN) but an RN must always be on site]. Nursing staff administers medications, follows up with families on medication compliance, and completes restraint assessments;
- (2) Medical director must be a licensed psychiatrist;
- (3) A psychiatrist/physician must be available twenty-four (24) hours a day, seven (7) days a week.
- (4) One (1) or more LBHPs or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).

(j) Reimbursement. PHP services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan. PHP reimbursement is all-inclusive of the service components, except for the following:

- (A) Physician services;
- (B) Medications;
- (C) Psychological testing by a licensed psychologist.

317:30-5-241.2.3 Partial hospitalization program (PHP) - Adults

(a) Definition. PHP is an intensive nonresidential, structured therapeutic treatment for individuals with substance use disorder, mental health diagnoses, and/or co-occurring disorders. It can be used as an alternative to and/or a step-down from inpatient or residential treatment, or to stabilize a deteriorating condition that may result in a need for inpatient or residential care. PHP services are:

- (1) Reasonable and necessary for the diagnosis or active treatment of the individual's condition;
and

(2) Reasonably expected to improve the individual's condition and functional level and to prevent relapse or hospitalization/residential care.

(b) **Eligibility criteria.** This service must be prior authorized by OHCA or its designated agent, and individuals must meet ongoing medical necessity criteria. Treatment is time limited, and length of participation is based on the individual's needs.

(c) **Eligible providers.** Provider agencies for PHP must be accredited to provide partial hospitalization services by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA) and enrolled in SoonerCare. The staff providing PHP services are employees or contractors of the enrolled agency. The agency is responsible for ensuring that all services are provided by properly credentialed clinicians.

(d) **Qualified practitioners.** Program services are overseen by a psychiatrist. The number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program. The clinical team includes the following required professionals:

(1) A licensed physician, physician's assistant, or advanced practice registered nurse [any of whom meet the requirements of an LBHP as described at OAC 317:30-5-240.3(a)];

(2) A registered nurse; and

(3) One (1) or more LBHPs or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).

(4) The clinical team may also include a certified behavioral health case manager.

(e) **Service components.** PHP service components include the following, provided by qualified professionals:

(1) Behavioral health/alcohol and drug assessment;

(2) Behavioral health/alcohol and drug service plan development;

(3) Individual/family/group therapy for behavioral health and/or substance abuse;

(4) Psychosocial rehabilitation services/substance abuse skills development (individual and group);

(5) Medication training and support;

(6) Case management;

(7) Crisis intervention services must be available twenty-four (24) hours a day, seven (7) days a week.

(f) **Limitations.** Treatment is time limited, based on medical necessity, and must offered at a minimum of three (3) hours per day, five (5) days a week. PHP cannot be billed in conjunction with the following services:

(1) Inpatient/residential psychiatric or residential substance use disorder services;

(2) Individual/family/group therapy for behavioral health; and/or substance abuse;

(3) Psychosocial rehabilitation services/substance abuse skills development (individual and group);

(4) Targeted case management (TCM);

(5) Mobile crisis intervention provided within the PHP setting;

(6) Peer recovery support;

(7) Program of Assertive Community Treatment (PACT);

(8) Certified Community Behavioral Health (CCBH) services.

(g) **Non-covered services.** The following services are not considered PHP and are not reimbursable:

(1) Room and board;

(2) Educational costs;

(3) Services to inmates of public institutions;

(4) Routine supervision and non-medical support services in school settings;

- (5) Child care;
- (6) Respite;
- (7) Personal care.

(h) **Documentation requirements.** Documentation needs to specify active involvement of the member. A nursing health assessment must be completed within twenty-four (24) hours of admission. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to OAC 317:30-5-248.

(i) **Staffing requirements.** Staffing must consist of the following:

- (1) A registered nurse (RN) trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available on-site during program hours to provide necessary nursing care and/or psychiatric nursing care [one (1) RN at a minimum can be backed up by a licensed practical nurse (LPN) but an RN must always be on site];
- (2) Medical director must be a licensed psychiatrist;
- (3) A psychiatrist/physician must be available twenty-four (24) hours a day, seven (7) days a week; and
- (4) One (1) or more LBHPs or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).

(j) **Reimbursement.** PHP services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan. PHP reimbursement is all-inclusive of the service components, except for the following:

- (1) Physician services;
- (2) Medications;
- (3) Psychological testing by a licensed psychologist.

317:30-5-241.2.4 Day treatment program

Day treatment programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

- (1) **Qualified practitioners.** All services in day treatment are provided by a team, which must be composed of one (1) or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP) or licensure candidate, a case manager, or other certified behavioral health/substance abuse paraprofessional staff. Services are directed by an LBHP.
- (2) **Qualified providers.** Provider agencies for day treatment must be accredited to provide day treatment services by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA).
- (3) **Limitations.** Services must be offered at a minimum of four (4) days per week at least three (3) hours per day. Behavioral health rehabilitation group size is limited to a maximum of eight (8) individuals as clinically appropriate given diagnostic and developmental functioning. Children under age six (6) are not eligible for behavioral health rehabilitation services unless a prior authorization for children ages four (4) and five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity.
- (4) **Service requirements.** On-call crisis intervention services must be available twenty-four (24) hours a day, seven (7) days a week (When members served have psychiatric needs,

psychiatric services are available which include the availability of a psychiatrist twenty-four (24) hours a day, seven (7) days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

(i) Family therapy at least one (1) hour per week (additional hours of family therapy may be substituted for other day treatment services);

(ii) Group therapy at least two (2) hours per week; and

(iii) Individual therapy at least one (1) hour per week.

(B) Additional services are to include at least one (1) of the following services per day:

(i) Medication training and support (nursing) once monthly if on medications;

(ii) Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in OAC 317:30-5-241.3 and is clinically necessary and appropriate except for children under age six (6), unless a prior authorization has been granted for children ages four (4) and five (5);

(iii) Behavioral health case management as needed and part of weekly hours for member;

(iv) Occupational therapy as needed and part of weekly hours for member; and

(v) Expressive therapy as needed and part of weekly hours for the member.

(5) **Documentation requirements.** Service plans are required every three (3) months. Records must be documented according to OAC 317:30-5-248.

(6) **Reimbursement.** Day treatment program services are reimbursed pursuant to the OHCA fee schedule based on the type and level of practitioner employed by the agency. All rates are published on the Agency's website www.oklahoma.gov/ohca.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

317:30-5-95.22. Coverage for children

(a) In order for services to be covered, services in psychiatric units of general hospitals, psychiatric hospitals, and PRTF programs must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for individuals aged twenty-one (21) and under are found in Sections OAC 317:30-5-95.22 through 317:30-5-95.42.

(b) The following words and terms, when used in OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "**Acute**" means care delivered in a psychiatric unit of a general hospital or psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.

(2) "**Acute II**" means care delivered in a psychiatric unit of a general hospital or psychiatric hospital; however, services at this level of care are designed to serve individuals under twenty-one (21) who need longer-term, more intensive treatment, and a more highly-structured environment than they can receive in family and other community-based alternatives to hospitalization. However, care delivered in this setting is less intense than the care provided in Acute.

(3) "**Border placement**" means placement in an inpatient psychiatric facility that is in one (1) of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas).

(4) "**Border status**" means placement in a facility in a state that does not border Oklahoma, but which facility routinely provides inpatient psychiatric services to SoonerCare members.

(5) "**Chemical dependency/substance abuse services/detoxification**" means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.

~~(6) "**Community-based extended**" means a PRTF with sixteen (16) beds or more but less than thirty (30) beds. The typical facility is not a locked facility.~~

~~(7) "**Community-based transitional (CBT)**" means a PRTF level of care designed for individuals under twenty-one (21) who require the continued structure and psychiatric intervention of twenty-four (24) hour care, but are ready to begin transitioning from more intense residential treatment into the community. It is the intent that members admitted to this level of care should be able to attend public school. Community-based transitional facilities are non-secure PRTFs with sixteen (16) beds or less.~~

~~(8)~~(6) "**Enhanced treatment unit or specialized treatment**" means an intensive residential treatment unit that provides a program of care to a population with special needs or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.

~~(9)~~(7) "**Evidence-based practice (EBP)**" means programs or practices that are supported by research methodology and have produced consistently positive patterns of results in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA).

~~(10)~~(8) "**Out-of-state placement**" means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.

~~(11)~~(9) "**Public facilities**" means Oklahoma government owned or operated facilities.

~~(12)~~(10) "**Trauma-informed**" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-95.29. Medical necessity criteria Acute II and PRTF admissions for children

~~(a)~~ Acute II and PRTF admissions for individuals under twenty-one (21) must meet the terms and conditions in (1), (2), (3), (4), (5) and one (1) of the terms and conditions of (6)(A) through (D) of this subsection.

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis.

(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior, or status offenses).

(3) Patient has either received treatment in an acute setting or it has been determined by the OHCA, or its designated agent, that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.

(4) Member must be medically stable.

(5) Requires twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management;

(B) Intensive treatment with the family/guardian and child in a structured milieu; and

(C) Intensive treatment in preparation for re-entry into community.

(6) Within the past fourteen (14) calendar days, the patient has demonstrated an escalating pattern of self-injurious or assaultive behaviors as evidenced by any of (A) through (D) below. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).

(A) Suicidal ideation and/or threat.

(B) History of/or current self-injurious behavior.

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

~~(b)~~ CBT admissions for children must meet the terms and conditions in (1) through (6) of this subsection.

~~(1) A primary diagnosis from the DSM-V with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavioral, or status offenses).~~

~~(3) Patient has either received treatment in Acute, Acute II, PRTF or children's crisis unit setting (refer to OAC 317:30-5-241.4), or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.~~

~~(A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.~~

~~(B) Clinical documentation must support need for CBT, rather than facility based crisis stabilization, therapeutic foster care, intensive treatment foster care, or intensive outpatient services.~~

~~(C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least two (2) of the five (5) critical areas, listed below, placing the member at risk of need for acute stabilization/inpatient care.~~

~~(i) Personal safety;~~

~~(ii) Cognitive functioning;~~

~~(iii) Family relations;~~

~~(iv) Interpersonal relations; or~~

~~(v) Educational/vocational performance.~~

~~(4) Child must be medically stable.~~

~~(5) Within the past fourteen (14) calendar days, the patient must have demonstrated an escalating pattern of self-injurious or assaultive behavior as evidenced by any of (a)(5)(A) through (D) above. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).~~

~~(6) Within the past fourteen (14) calendar days, the patient's behaviors have created significant functional impairment.~~

317:30-5-95.30. Medical necessity criteria for Acute II and PRTF continued stay for children

~~(a)~~ For continued stay in Acute II and PRTF programs, members must meet the terms and conditions contained in (1), (2), (3), (4), and either (5) or (6) of this subsection:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V codes, adjustment disorders, and substance abuse-related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, members eighteen (18) to twenty (20) years of age may have a secondary diagnosis of any personality disorder.

(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).

(3) There is documented continuing need for twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and child in a structured milieu.

(C) Intensive treatment in preparation for re-entry into community.

(4) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

(5) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.

(A) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.

(B) Patient has made gains toward social responsibility and independence.

(C) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.

- (D) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.
- (6) Child's condition has remained unchanged or worsened.
 - (A) Documentation of regression is measured in behavioral terms and reflected in the patient's treatment and discharge plans.
 - (B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.
- ~~(b) For continued stay in a CBT, members must meet the terms and conditions found in (1) through (5) of this subsection.~~
 - ~~(1) A primary diagnosis from the DSM-V with the exception of V-codes, adjustment disorders, and substance use disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.~~
 - ~~(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).~~
 - ~~(3) There is documented continued need for twenty-four (24) hour observation and treatment as evidenced by:
 - ~~(A) Patient making measurable progress toward the treatment objectives specified in the treatment plan.~~
 - ~~(B) Clinical documentation clearly indicates continued significant functional impairment in two (2) of the following five (5) critical areas, as evidenced by specific clinically relevant behavior descriptors:
 - ~~(i) Personal safety;~~
 - ~~(ii) Cognitive functioning;~~
 - ~~(iii) Family relations;~~
 - ~~(iv) Interpersonal relations; or~~
 - ~~(v) Educational/vocational performance.~~~~~~
 - ~~(4) Clinical documentation includes behavioral descriptors indicating patient's response to treatment and supporting patient's ability to benefit from continued treatment at this level of care.~~
 - ~~(5) Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment process.~~

317:30-5-95.33. Individual plan of care for children

- (a) An individual plan of care (IPC) is a written plan developed for each member within four (4) calendar days of admission to an Acute, Acute II, or a PRTF that directs the care and treatment of that member. The IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender and include:
 - (1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance abuse-related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis;
 - (2) The current functional level of the individual;
 - (3) Treatment goals and measurable, time-limited objectives;
 - (4) Any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health

and safety of the member;

(5) Plans for continuing care, including review and modification to the IPC; and

(6) Plan for discharge, all of which is developed to improve the member's condition to the extent that the inpatient care is no longer necessary.

(b) The IPC:

(1) Must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) Must be developed by a team of professionals in consultation with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:

(A) For a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by OAC 317:30-5-95.35(b)(2), per 42 C.F.R. §§ 441.155 and 483.354; or

(B) For a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:

(i) An allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(ii) A registered nurse (RN) with a minimum of two (2) years of experience in a mental health treatment setting; and

(iii) An LBHP.

(3) Must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goals must be appropriate to the member's age, culture, strengths, needs, abilities, preferences, and limitations;

(4) Must establish measurable and time-limited treatment objectives that reflect the expectations of the member served and parents/legal guardians (when applicable), as well as being age, developmentally, and culturally appropriate. When modifications are being made to accommodate age, developmental level, or a cultural issue, the documentation must be reflected on the IPC. The treatment objectives must be achievable and understandable to the member and the parents/legal guardians (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) Must prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;

(6) Must include specific discharge and aftercare plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, aftercare plans will include referral to medication management, outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into his or her family, school, and community;

(7) Must be reviewed, at a minimum, every nine (9) calendar days for members admitted to Acute; every fourteen (14) calendar days for members admitted to Acute II or non-specialty PRTF; every twenty-one (21) calendar days for members admitted to an OHCA-approved longer-term treatment program or specialty Acute II or PRTF; ~~and every thirty (30) calendar days for members admitted to a CBT PRTF.~~ Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided

are or were required on an inpatient basis, and to recommend changes in the IPC as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) Development and review must satisfy the utilization control requirements for recertification [42 C.F.R. §§ 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. §§ 456.80, 456.180, and 456.380); and,

(9) Each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen (18)], and required team members. ~~All IPCs and IPC 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 or her from signing. If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. IPCs and IPC reviews are not valid until completed and appropriately signed and dated. All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited. If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent/legal guardian and/or OKDHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.~~

(A) All IPCs and IPC 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 or her from signing.

(i) If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(ii) The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

(B) IPCs and IPC reviews are not valid until completed and appropriately signed and dated.

(i) All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited.

(ii) If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them.

(iii) Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file.

(iv) In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent/legal guardian and/or

OKDHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.

(10) Medically necessary Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) services shall be provided to members, under the age of twenty-one (21), who are residing in an inpatient psychiatric facility, regardless of whether such services are listed on the IPC. Reimbursement for the provision of medically necessary EPSDT services to individuals under age twenty-one (21), while the member is residing in an inpatient psychiatric facility, will be provided in accordance with the Oklahoma Medicaid State Plan.

317:30-5-95.34. Active treatment for children

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

(1) "**Active treatment**" means implementation of a professionally developed and supervised individual plan of care (IPC) that involves the member and his or her family or guardian from the time of an admission, and through the treatment and discharge process.

(2) "**Discharge/transition planning**" means a patient-centered, interdisciplinary process that begins with an initial assessment of the member's needs at the time of admission and continues throughout the member's stay. Active collaboration with the member, family, and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management, and other supports in the member's community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(3) "**Expressive group therapy**" means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, and experiential (e.g., ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(4) "**Family therapy**" means interaction between an LBHP or licensure candidate, member, and family member(s) to facilitate emotional, psychological, or behavioral changes and promote successful communication and understanding.

(5) "**Group rehabilitative treatment**" means behavioral health remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).

(6) "**Individual rehabilitative treatment**" means a face-to-face, one-on-one interaction which is performed to assist a member who is experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder, in order to increase the skills necessary to perform ADL.

(7) "**Individual therapy**" means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(8) "**Process group therapy**" means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate, and two (2) or more members to promote positive emotional and/or behavioral

change.

(b) Inpatient psychiatric programs must provide "active treatment". Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well-documented in the member's treatment plan. Family therapy attendance by family members is not a requirement for individuals in the age range of eighteen (18) up to twenty-one (21). Active treatment also includes ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician.

(c) For individuals ~~ages~~ ages eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and the IPC must be recovery-focused, trauma-informed, specific to culture, age, and gender, and provided face to face. Services, including type and frequency, will be specified in the IPC.

(d) A treatment week consists of seven (7) calendar days. In an Acute setting, the treatment week begins the day of admission. In Acute II and PRTF, the treatment week starts on Sunday and ends on Saturday. Active treatment service components are provided as per item (e) below if the services are provided within a seven (7) day treatment week. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. If a member has a length of stay of less than seven (7) days, the treatment week is considered a partial treatment week. Active treatment requirements, when provided during a partial treatment week, are delivered as per item (f) below. An hour of treatment must be sixty (60) minutes. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each, on the condition that the active treatment requirements are fully met by the end of the treatment week.

(e) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender. Individuals receiving services in an Acute setting must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours dedicated to core services as described in (1) below. Individuals in Acute II and PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below. ~~Individuals in CBT PRTFs must receive ten (10) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below.~~ Upon fulfilling the core service hours requirement, the member may receive either the elective services listed in (2) below or additional core services to complete the total required hours of active treatment. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three (3) times per week for Acute and one (1) time a week in Acute II and PRTFs. Individual treatment provided by the physician will never exceed ten (10) calendar days between sessions in Acute II and PRTFs, and never exceed seven (7) calendar days in a specialty Acute II and specialty PRTF, and never exceed thirty (30) calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for Acute, Acute II, and PRTF programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use

and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution-focused brief therapy, or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment, as well as psycho-educational intervention, are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal-directed, utilizing techniques appropriate to the member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in Acute and one (1) hour per week in Acute II and PRTFs by an LBHP or licensure candidate. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week in Acute, Acute II, and PRTFs. One (1) hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in Acute and two (2) hours per week in Acute II and PRTFs by an LBHP or licensure candidate. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy provided by an LBHP, licensure candidate, or licensed therapeutic recreation specialist may be substituted.

(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in Acute and thirty (30) minutes per week in Acute II and PRTFs. Transition/discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, ~~inner strengths~~ inner strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes, and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives directly related to the IPC.

(C) **Individual rehabilitative treatment.** Services are provided to reduce psychiatric and behavioral impairment and to restore functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes, and recovery principles and practices. Each individual rehabilitative

treatment service provided must have goals and objectives directly related to the IPC and the member's diagnosis.

(D) **Recreation therapy.** Services are provided to reduce psychiatric and behavioral impairment and to restore, remediate, and rehabilitate an individual's level of functioning and independence in life activities. Services are provided to promote health and wellness, as well as reduce or eliminate barriers caused by illness or disabling conditions that limit or restrict a member from participating in life activities. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e., to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a licensed therapeutic recreation specialist.

(E) **Occupational therapy.** Services are provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor, and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which he or she practices.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote physical health. The focus of these activities should include areas such as nutrition, exercise, support to avert and manage physical health concerns like heart disease, diabetes, and cholesterol, and guidance on the effects that medications have on physical health. Services can include ~~individual/group~~ individual/group support, exercise groups, and individual physical wellness plan development, implementation, and assistance.

(3) **Modifications to active treatment.** When a member is too physically ill, or his or her acuity level precludes him or her from active behavioral health treatment, documentation must demonstrate that alternative clinically-appropriate services were provided.

(f) Active treatment components, furnished during a partial treatment week, are provided as per item (1) through (4) below. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. Assessments/evaluations may serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In Acute, by day two (2), one (1) visit is required. By day four (4), two (2) visits are required. By day seven (7), three (3) visits are required.

(B) In Acute II and PRTFs, one (1) visit during admission week is required. In PRTFs, ~~not including CBTs~~, one (1) visit during the admission week is required, then once a week thereafter. ~~In CBT, one (1) visit is required within seven (7) days of admission, then once a month thereafter.~~ Individual treatment provided by the physician will never exceed ten (10) days between sessions in Acute II and PRTFs, never exceed seven (7) days in specialty Acute II and specialty PRTFs ~~and never exceed thirty (30) days in CBTs~~. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within sixty (60) hours of admission time.

(2) Individual therapy.

(A) In Acute, by day three (3), thirty (30) minutes of treatment are required. By day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week. This does not include admission assessments/evaluations or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ten (10) days between sessions. This does not include admission assessment/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) Family therapy.

(A) In Acute, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admission assessments/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ten (10) days in between sessions.

(4) Process group therapy.

(A) In Acute, by day three (3), one (1) hour of treatment is required. By day five (5), two (2) hours of treatment are required. Beginning on day seven (7), three (3) hours of treatment are required each week.

(B) In Acute II and PRTFs, by day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week.

(g) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff [registered nurse (RN)/licensed practical nurse (LPN)], documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children

The member's medical record must contain complete medical, psychiatric, and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within twenty-four (24) hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) in Acute, Acute II, and PRTFs, ~~excluding CBTs, and within seven (7) calendar days of admission in a CBT.~~

(B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an

allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry in Acute, Acute II, and PRTFs, ~~excluding CBTs, and within seven (7) calendar days of admission in a CBT.~~

(C) Psychosocial evaluation must be completed within seventy-two (72) hours of an Acute admission, and within seven (7) calendar days of admission to Acute II and PRTFs; ~~including CBTs,~~ by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), LBHP, or licensure candidate.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than thirty (30) calendar days from admission. For continued stays at the same level of care, evaluations remain current for twelve (12) months from the date of admission and must be updated annually within seven (7) calendar days of that anniversary date.

(4) Existing evaluations of thirty (30) days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary, and signed and dated by the appropriate level of professional as defined by the type of evaluation.

317:30-5-95.38. Nursing services for children

Each facility must have a qualified director of psychiatric nursing. In addition to the director of nursing, there must be adequate numbers of registered nurses (RNs), licensed practical nurses (LPNs), and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. ~~In a CBT, an RN must be on site at least one (1) hour each day and be available twenty four (24) hours a day when not on site. An RN must document member progress at least weekly, except in a CBT where the requirement will be twice a month.~~ The progress note must contain recommendations for revisions in the individual plan of care (IPC), as needed, as well as an assessment of the member's progress as it relates to the IPC goals and objectives.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

**PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT
(EPSDT) PROGRAM/CHILD-HEALTH SERVICES**

317:30-3-65.12. Applied behavior analysis (ABA) services

(a) ~~**Purpose and general provisions.** The purpose of this Section is to establish guidelines for the provision of ABA services under the EPSDT benefit.~~

~~(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include, but are not limited to; discrete trial training (DTT); naturalistic developmental behavioral intervention (NDBI); and verbal behavioral intervention.~~

~~(2) ABA may be provided in a variety of settings, including home, community, or a clinical setting. It involves development of an individualized treatment plan that includes transition and aftercare planning, and family/caregiver involvement.~~

~~(3) At an initial assessment, target symptoms are identified. A treatment plan is developed to identify core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and that are functional, meaningful and connected to the member's daily activities routines.~~

~~(4) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-3-65.12(e)].~~

(b) **Functional behavior assessment (FBA) and treatment plan components**

(1) The FBA serves as a critical component of the treatment plan and is conducted by a board certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The FBA consists of:

(A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);

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

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

(D) Consequence analysis; and

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

(2) The treatment plan is developed by a BCBA or a licensed psychologist from the FBA. The treatment plan shall:

(A) Be person-centered and individualized;

(B) Delineate the baseline levels of target behaviors;

(C) Specify long and short-term objectives that are defined in observable, measurable behavioral terms;

(D) Specify criteria that will be used to determine achievement of objectives;

(E) Include assessment and treatment protocols for addressing each of the target behaviors;

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

needed:-

~~(G) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;-~~

~~(H) Include training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan;-~~

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

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

~~(c) **Eligible providers.** Eligible ABA provider types include:-~~

~~(1) Board certified behavior analyst⁷ (BCBA⁷) ~~B~~ A master's or doctoral level independent practitioner who is certified by the national accrediting Behavior Analyst Certification Board, Inc.⁷ (BACB⁷) and licensed by the Oklahoma Department of Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;~~

~~(2) Board certified assistant behavior analyst⁷ (BCaBA⁷) ~~B~~ A bachelor's level practitioner who is certified by the national accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;~~

~~(3) Registered behavior technicianTM (RBT⁷) ~~B~~ A high school level or higher paraprofessional who is certified by the national accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior analytic services;~~

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

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

~~(A) A licensed physical therapist;~~

~~(B) A licensed occupational therapist;~~

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

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

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

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

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

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

~~(1) A BCBA shall:~~

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

(2) A BCaBA shall:

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

(3) An RBT shall:

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

(4) A human services professional shall:

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

(e) Medical necessity criteria for members under twenty-one (21) years of age. ABA services are considered medically necessary when all of the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

- (A) Pediatric neurologist or neurologist;
- (B) Developmental pediatrician;
- (C) Licensed psychologist;
- (D) Psychiatrist or neuropsychiatrist; or
- (E) Other licensed physician experienced in the diagnosis and treatment of ASD.

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

- (A) Be completed within the last two (2) years;
- (B) Include a complete pertinent medical and social history, including pre and perinatal, medical, developmental, family, and social elements; and
- (C) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic

~~Interview Revised (ADI-R), Autism Diagnostic Observation Schedule 2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.~~

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

~~(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and~~

~~(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.~~

~~(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).~~

~~(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:~~

~~(A) Impulsive aggression toward others;~~

~~(B) Self-injury behaviors;~~

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

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

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

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

~~(f) **Prior authorization.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following SoonerCare criteria for ABA services:~~

~~(1) The criteria includes a comprehensive behavioral and FBA outlining the maladaptive behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit documentation that will consist of the following:~~

~~(A) Information about relevant medical status, prior assessment results, response to prior~~

~~treatment, and other relevant information gathered from review of records and past assessments.~~

~~(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.~~

~~(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing and adapting treatment protocols, and evaluating response to treatment and progress towards goals.~~

~~(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.~~

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

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

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

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

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

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

~~(F) Set quantifiable criteria for progress;~~

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

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

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

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

~~(K) Document parent(s)/legal guardian(s) participation in the training of behavioral~~

techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment; and
(L) Ensure that recommended ABA services do not duplicate or replicate services received in a member's primary academic education setting, or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

(g) ABA extension requests. Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

- (1) Eligibility criteria in OAC 317:30-3-65.12(d) 1-6;
- (2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;
- (3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;
- (4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);
- (5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;
- (6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and
- (7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.

(h) Reimbursement methodology. SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

- (1) Payment shall only be made to SoonerCare contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.
- (2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.
- (3) Reimbursement shall only be made for services that have been prior authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider [OAC 317:30-3-65.12(b)].
- (4) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

ABA services are provided under the EPSDT benefit. Refer to OAC 317:30-5-310 through

317:30-5-316 for coverage, provider and program requirements, and reimbursement methodology.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 30. APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES

317:30-5-310. Purpose

The purpose of this Section is to establish guidelines for the provision of ABA services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include but are not limited to; discrete trial training (DTT); naturalistic developmental behavioral intervention (NDBI); and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or clinical. It involves development of an individualized treatment plan that includes transition and aftercare planning, and family/caregiver involvement.

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed to identify core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and that are functional, meaningful, and connected to the member's daily activities routines.

(4) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-314].

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

(a) Eligible ABA provider types include:

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

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

(3) Registered behavior technician™ (RBT®) – A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services;

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

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

(A) A licensed physical therapist;

- (B) A licensed occupational therapist;
- (C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;
- (D) A licensed speech-language pathologist or licensed audiologist;
- (E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;
- (F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or
- (G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

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

(1) A BCBA shall:

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

(2) A BCaBA shall:

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

(3) An RBT shall:

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

(4) A human services professional shall:

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

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

(a) Treatment plan. The treatment plan is developed by a BCBA or a licensed psychologist from the FBA. The treatment plan shall:

- (1) Be person-centered and individualized;
- (2) Delineate the baseline levels of target behaviors;
- (3) Specify long-term and short-term objectives that are defined in observable, measurable behavioral terms;
- (4) Specify criteria that will be used to determine achievement of objectives;
- (5) Include assessment(s) and treatment protocols for addressing each of the target behaviors such as including antecedent and consequence interventions, and teaching of replacement skills specific to the function of the identified maladaptive behaviors;
- (6) Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed;
- (7) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;
- (8) Include training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan in the home and community settings;
- (9) Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
- (10) Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

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

(1) The functional behavior assessment (FBA) serves as a critical component of the treatment plan and is conducted by a board-certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The FBA consists of:

- (A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, and severity);
- (B) History of the problematic behavior (long-term and recent);
- (C) Antecedent analysis (setting, people, time of day, and events);
- (D) Consequence analysis; and
- (E) Impression and analysis of the function of the problematic behavior.

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

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

- (1) Document all ABA services in the member's record. Refer to OAC 317:30-5-248;
- (2) Retain the member's records necessary to disclose the extent of services. Refer to OAC 317:30-3-15; and
- (3) Release the medical information necessary for payment of a claim upon request. Refer to OAC 317:30-3-16.
- (4) All assessment and treatment services must include the following:
 - (A) Date;
 - (B) Start and stop time for each session/unit billed and physical location where service was provided;
 - (C) Signature of the provider;
 - (D) Credentials of provider;

- (E) Specific problem(s), goals and/or objectives addressed;
- (F) Methods used to address problem(s), goals and objectives;
- (G) Progress made toward goals and objectives;
- (H) Patient response to the session or intervention; and
- (I) Any new problem(s), goals and/or objectives identified during the session.
- (J) Treatment plans are not valid until all signatures are present. As used in this subsection, all signatures mean:
 - (i) The signature of acknowledgement of the supervising BCBA or licensed psychologist; and
 - (ii) The signature of assent of any minor who is age fourteen (14) or older; and
 - (iii) The signature of consent of:
 - (I) A parent or legal guardian of any minor; or
 - (II) If the minor documents a legal exception to parent or legal guardian consent, the excepted minor.
 - (iv) All signatures:
 - (I) Must clearly indicate that the signatories approve of and consent, assent, or acknowledge the treatment plan; and
 - (II) May be provided on a signature page applicable to both the assessment and the treatment plan, if the signed page clearly indicates approval of and consent, assent, or acknowledgment of both the assessment and the treatment plan.

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

ABA services are considered medically necessary when all the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

- (A) Pediatric neurologist or neurologist;
- (B) Developmental pediatrician;
- (C) Licensed psychologist;
- (D) Psychiatrist or neuropsychiatrist; or
- (E) Other licensed physician experienced in the diagnosis and treatment of ASD.

(2) A comprehensive diagnostic evaluation or thorough clinical assessment completed by one

(1) of the above identified professionals must:

- (A) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and
- (B) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

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

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

associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

(A) Impulsive aggression toward others;

(B) Self-injury behaviors;

(C) Intentional property destruction; or

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

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

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

317:30-5-314. Prior authorization

Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following SoonerCare criteria for ABA services.

(1) The criteria include a comprehensive behavioral assessment, FBA, and other supporting assessment(s) outlining the maladaptive behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit documentation that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment

levels of functioning, developing, and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

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

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

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

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

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

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

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

(F) Set quantifiable criteria for progress;

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

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

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

(J) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

(K) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment; and

(L) Ensure that recommended ABA services do not duplicate, or replicate services received in a member's primary academic education setting or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services

with other providers and to prevent overlap and duplication of services including those in school settings.

317:30-5-315. ABA extension requests

Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

- (1) Eligibility criteria in OAC 317:30-5-313;
- (2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;
- (3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;
- (4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);
- (5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;
- (6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and
- (7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.

317:30-5-316. Reimbursement methodology

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

- (1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.
- (2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.
- (3) Reimbursement shall only be made for services that have been prior authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider (OAC 317:30-5-311).
- (4) Providers may only concurrently bill current Procedural Terminology (CPT) codes when they outline in the prior authorization the following criteria:
 - (A) The BCBA or licensed psychologist met with the member and/or parent or guardian and directed the RBT through one (1) or more of the following:
 - (i) Monitoring treatment integrity to ensure satisfactory implementation of treatment

protocols;

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

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

(iv) Collaboration with family members and other stakeholders;

(v) Creating materials, gathering materials;

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-22. Obstetrical care

(a) Obstetrical (OB) care is billed using the appropriate CPT codes for ~~Maternity Care and Delivery~~maternity care and delivery. The date of delivery is used as the date of service for charges for total OB care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total OB care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one (1) trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the antepartum visits. The antepartum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

(b) Procedures paid separately from total OB care are listed in (1) - (8) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG₂ and the most recent version of the Oklahoma Health Care Authority's (OHCA) Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one (1) assessment per provider and no more than two (2) per pregnancy.

(2) Medically necessary real time antepartum diagnostic ultrasounds will be paid in addition to antepartum care, delivery, and postpartum OB care under defined circumstances. To be eligible for payment, all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One (1) ultrasound will be covered in the first trimester of an uncomplicated pregnancy. Both an abdominal and vaginal ultrasound may be allowed when clinically appropriate and medically necessary. The ultrasound must be performed by a ~~Board Eligible/Board Certified Obstetrician-Gynecologist~~ board eligible/board certified obstetrician-gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a ~~Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics~~certified nurse midwife (CNM), family practice physician or advanced practice nurse practitioner (APRN) in obstetrics with a certification in OB ultrasonography.

(B) One (1) ultrasound after the first trimester will be covered. This ultrasound must be performed by a ~~Board Eligible/Board Certified OB-GYN, Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine~~ board eligible/board certified OB-GYN, radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a ~~Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics~~CNM, family practice physician, or APRN with certification in OB ultrasonography.

(C) One (1) additional detailed ultrasound is allowed by a ~~Board Eligible/Board Certified Maternal-Fetal Specialist~~board eligible/board certified maternal fetal specialist or general

obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at ~~Cesarean Section (C-Section)~~cesarean section (C-section), for the purpose of attending the baby, is compensable when billed by a physician or qualified health care provider not participating in the delivery.

(4) Anesthesia administered by the attending physician is a compensable service and may be billed separately from the delivery.

(5) Amniocentesis is not included in routine OB care and is billed separately. Payment may be made for an evaluation and management service and a medically indicated amniocentesis on the same date of service. This is an exception to general information regarding surgery found at Oklahoma Administrative Code (OAC) 317:30-5-8.

(6) Additional payment is not made for the delivery of multiple gestations. If one (1) fetus is delivered vaginally and additional fetus(es) are delivered by C-section by the same physician, the ~~higher level~~higher-level procedure is paid. If one (1) fetus is delivered vaginally and additional fetus(es) are delivered by ~~C-Section~~C-section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at ~~C-Section~~C-section.

(7) Reimbursement is allowed for nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(8) Limited OB ultrasounds are covered in an emergency room (ER) setting when medically necessary.

(c) Assistant surgeons are paid for ~~C-Sections~~C-sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at ~~C-Section~~C-section bill separately for the prenatal and the six (6) weeks postpartum office visit.

(d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total OB care.

(1) Non stress test, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at ~~C-Section~~C-section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for an assistant surgeon for OB procedures that include prenatal or postpartum care.

(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

(5) Fetal scalp blood sampling is considered part of the total OB care.

(e) OB coverage for children is the same as for adults. Additional procedures may be covered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions if determined to be medically necessary.

(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health Program even though those services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more

information regarding experimental or investigational and clinical trials see OAC 317:30-3-57.1.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 5. PHARMACIES**

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

~~(a) The purpose of this Section is to provide special provisions for providers participating in the 340B Drug Discount program. The 340B Drug Discount program special provisions apply to a provider that has asserted it is a "covered entity" or a contract pharmacy for a covered entity under the provisions of 42 U.S.C. § 256b of the United States Code (otherwise known as the 340B Drug Discount Program).~~

~~(b) Covered Entities.~~

~~(1) The covered entity must notify OHCA in writing within 30 days of any changes in 340B participation, as well as any changes in name, address, NPI number, etc.~~

~~(2) The covered entity must maintain their status on the HRSA Medicaid exclusion file and report any changes to OHCA within 30 days.~~

~~(3) The covered entity must execute a contract addendum with OHCA in addition to their provider contract.~~

~~(4) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by the covered entity. OHCA will adjust each claim by subtracting the 340B Ceiling Price from the amount reimbursed and multiplying the difference by the quantity submitted. All drugs shall be adjusted by the 340B Ceiling Price whether purchased through the 340B program or otherwise when billed using the registered SoonerCare NPI number on the HRSA Medicaid Exclusion File. OHCA will use the 340B Ceiling Price applicable to the quarter in which the claim is paid.~~

~~(c) 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 OHCA, the contract pharmacy and the covered entity. These pharmacies will be subject to the recovery process stated above.~~

(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.

(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.

(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 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH 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~~Other OHCA approved accreditation.

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

"AOD" means ~~Alcohol~~alcohol and ~~Other Drug~~other drug.

"AODTP" means ~~Alcohol and Other Drug Treatment Professional~~alcohol and other drug treatment professional.

"ASAM" means the American Society of Addiction Medicine.

"ASAM Patient Placement Criteria"~~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"~~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~~behavioral health aides.

"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 ~~use of~~ 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~~evidence-based practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"EPSDT" means the ~~Medicaid~~ 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~~ facility-based crisis stabilization.

"FSPs" means ~~Family Support Providers~~ family support providers.

"ICF/IID" means ~~Intermediate Care Facility for Individuals with Intellectual Disabilities~~ intermediate care facility for individuals with intellectual disabilities.

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

"IMD" means ~~Institution for Mental Disease~~ 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~~ 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 ~~Oklahoma Administrative Code~~, 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~~ 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 ~~also~~ contract directly with the Oklahoma Health Care Authority to provide ~~Outpatient Behavioral Health Services~~ 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~~ 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~~ peer recovery support specialist.

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

"~~Serious Emotional Disturbance~~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~~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~~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.

PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-266. Covered services

CCBHCs provide a comprehensive array of services that create access, stabilize people in crisis, and provide the needed treatment and recovery support services for those with the most serious and complex mental health and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. Initial screening, assessment, and diagnosis must be completed in order to receive a covered service. Services must be medically necessary and recommended by an LBHP or licensure candidate (see OAC 317:30-5-263). Services are covered when provided in accordance with a person-centered and family-centered service plan. Coverage includes the following services:

(1) Crisis assessment and intervention services.

(A) **Service requirements.** This service is an immediately available service designed to meet the psychological, physiological, and environmental needs of individuals who are experiencing mental health and/or substance use disorder crises. Services include the following:

(i) Twenty-four (24) hours mobile crisis teams [see OAC 317:30-5-241.4(a) for service definition]. Reimbursement is triggered by the LBHP/licensure candidate crisis assessment;

(ii) Emergency crisis intervention service [see OAC 317:30-5-241.4(a) for service definition]; ~~and~~

(iii) Facility-based crisis stabilization [see OAC 317:30-5-241.4(b) for service definition], provided directly by the CCBHC or by a State-sanctioned alternative; ~~and~~
and

(iv) Urgent recovery clinic (URC) services provided in accordance with OAC 450:23-3-20 through 450:23-3-24.

(B) **Qualified professionals.** Twenty-four (24) hours mobile crisis intervention is provided by either a team consisting of an LBHP/licensure candidate and a CM II or CADC, or just an LBHP/licensure candidate. Emergency crisis intervention is provided by an LBHP/licensure candidate. Facility-based crisis stabilization is provided by a team, directed by a physician, and consisting of an LBHP/licensure candidate, licensed nurses, CM II or CADC, and PRSS staff. URC services are provided by an LBHP/licensure candidate with supervision from a physician or APRN with prescribing authority.

(2) **Behavioral health integrated (BHI) services.**

(A) **Service requirements.** This service includes activities provided that have the purpose of coordinating and managing the care and services furnished to each member, assuring a fixed point of responsibility for providing treatment, rehabilitation, and support services. This service includes, but is not limited to:

- (i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals, and PRTFs;
- (ii) Ensuring integration and compatibility of mental health and physical health activities;
- (iii) Providing on-going service coordination and linking members to resources;
- (iv) Tracking completion of mental and physical health goals in member's comprehensive care plan;
- (v) Coordinating with all team members to ensure all objectives of the comprehensive care plan are progressing;
- (vi) Appointment scheduling;
- (vii) Conducting referrals and follow-up monitoring;
- (viii) Participating in hospital discharge processes; and
- (ix) Communicating with other providers and members/family.

(B) **Qualified professionals.** This service is performed by an LBHP/licensure candidate, nurse, CM II or CADC, and/or PRSS staff.

(3) **Person-centered and family-centered treatment planning.**

(A) **Service requirements.** This service is a process in which the information obtained in the initial screenings and assessments are used to develop a treatment plan that has individualized goals, objectives, activities, and services that will enable the member to improve. For children assessed as SED with significant behavioral needs, treatment planning is a wraparound process consistent with System of Care values. A wraparound planning process supports children and youth in returning to or remaining in the community.

(B) **Qualified professionals.** This service is conducted by LBHPs/licensure candidates, nurses, CM II or CADC, and/or PRSS staff. Treatment planning must include the member and involved practitioners.

(4) **Psychotherapy (individual / group / family).**

(A) **Service requirements.** See OAC 317:30-5-241.2 for service definitions and requirements. Fee-for-service billing limitations do not apply.

(B) **Qualified professionals.** This service is conducted by an LBHP/licensure candidate.

(5) **Medication training and support.**

(A) **Service requirements.** This service includes:

- (i) A review and educational session focused on the member's response to medication

- and compliance with the medication regimen and/or medication administration;
- (ii) Prescription administration and ordering of medication by appropriate medical staff;
- (iii) Assisting the member in accessing medications;
- (iv) Monitoring medication response and side effects; and
- (v) Assisting members with developing the ability to take medications with greater independence.

(B) **Qualified professionals.** This service is performed by an RN, APRN, or a physician assistant (PA) as a direct service under the supervision of a physician.

(6) **Psychosocial rehabilitation services (PSR).**

(A) **Service requirements.**

(i) Adult. PSR services are face-to-face behavioral health rehabilitation (BHR) services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions through the format of curriculum-based education and skills training. This service is generally performed with only the member and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments, is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery but does not constitute family therapy, which requires a licensed provider. Eligibility requirements and billing limits found in OAC 317:30-5-241.3 do not apply.

(ii) Children. PSR services are an array of services that are provided in the child's home, in the location where behavioral challenges are most likely to occur such as school, or in community settings for all children, youth, and young adults ages zero (0) to twenty (20). PSR services must be provided in a context that is child-centered, family-focused, strength-based, culturally competent, and responsive to each child's psychosocial, developmental, and treatment care needs. PSR service array includes:

- (I) Intensive in-home services;
- (II) Therapeutic behavioral services;
- (III) Intensive family intervention; and
- (IV) Intensive outpatient substance abuse rehabilitation.

(B) **Qualified professionals.** This service is solely restorative in nature and may be performed by a behavioral health CM II, CADC, LBHP, or licensure candidate, following development of a service plan and treatment curriculum approved by an LBHP or licensure candidate. ~~The behavioral health CM II and CADC~~For children, services are typically provided by a team that can offer a combination of therapy from a LBHP or licensure candidate and skills training and support from a paraprofessional [CM II, behavioral health aide (BHA)]. The behavioral health CM II, CADC, and BHA must have immediate access to an LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services.

(7) **Psychoeducation and counseling.**

(A) **Service requirements.** This service is designed to restore, rehabilitate, and support the individual's overall health and wellness. Services are intended for members to provide purposeful and ongoing psychoeducation and counseling that are specified in the individual's person-centered, individualized plan of care. For children and their families, treatment services are an array of therapeutic strategies and services designed to ameliorate or reduce the risk of social, emotional, and behavioral disorders and disruptions in the relationship between an infant and parent/caregiver. Such disorders and disruptions may be due to infant/toddler and/or parent/caregiver vulnerabilities and/or negative environmental factors that are significantly impacting the infant and/or parent/caregiver-infant relationship. Treatment services are grounded in attachment theory and are relationship focused. Components include:

- (i) Delivery of manualized wellness management interventions via group and individual work such as WRAP or IMR/WMR; and
- (ii) Emotional support, education, resources during periods of crisis, and problem-solving skills.

(B) **Qualified professionals.** For children, zero (0) to five (5) years old, this service is provided by an LBHP or licensure candidate. For all other ages, this service is provided by a licensed nurse, licensed nutritionist, or CM II or CADC within the scope of their licensure, certification, and/or training.

(8) **Peer recovery support services.**

(A) **Service requirements.** See OAC 317:30-5-241.5(d) for service requirements.

(B) **Qualified professionals.** PRSS must be certified through ODMHSAS pursuant to OAC 450:53.

(9) **Family support and training.**

(A) **Service requirements.** See OAC 317:30-5-241.5(c) for service requirements.

(B) **Qualified professionals.** Family support providers must be trained/credentialed through ODMHSAS.

(10) **Screening, assessment, and service planning.**

(A) **Service requirements.** See OAC 317:30-5-241.1 for service requirements. Service billing limitations found in OAC 317:30-5-241.1 do not apply.

(B) **Qualified professionals.** Screenings can be performed by any qualified team member as listed in OAC 317:30-5-265(b). Assessment and service planning can only be performed by an LBHP or licensure candidate.

(11) **Occupational therapy.**

(A) **Service requirements.** This service includes the therapeutic use of everyday life activities (occupations) with an individual or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings for the purpose of promoting health and wellness. Occupational therapy services are provided to those who have developed an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

(B) **Qualified professionals.** This service is solely restorative in nature and provided by a qualified occupational therapist who is contracted with the OHCA or an occupational therapist assistant who is working under the supervision of a licensed occupational therapist (see OAC 317:30-5-295).

(C) **Coverage limitations.** In order to be eligible for SoonerCare reimbursement, occupational therapy services must be prior authorized and/or prescribed by a physician or other licensed practitioner of the healing arts, in accordance with State and federal law, including, but not limited to, OAC 317:30-5-296, OAC 317:30-5-1020, and 42 C.F.R. § 440.110.

(12) Behavioral health targeted case management.

(A) Service requirements. See OAC 317:30-5-241.6 for service requirements.

(B) Qualified professionals. This service is provided by a CM II certified in accordance with OAC 450:50.

(C) Coverage limitations. Services are provided to individuals of all ages who meet medical necessity criteria.

(13) Outpatient substance abuse prevention counseling.

(A) Service requirements. This service provides counseling to enable individuals to successfully resist social and other pressures to engage in destructive activities.

(B) Qualified professionals. This service must be recommended by a physician or licensed practitioner and provided by LBHP/licensure candidate.

(C) Coverage limitations. Services are provided to individuals under age twenty-one (21) who meet medical necessity criteria.

317:30-5-267. Reimbursement

(a) In order to be eligible for payment, CCBHCs must have an approved provider agreement on file with the OHCA. Through this agreement, the CCBHC assures that OHCA's requirements are met and assures compliance with all applicable federal and state Medicaid law, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan. These agreements are renewed annually with each provider.

(b) Reimbursement is made using a provider-specific prospective payment system (PPS) rate developed based on provider-specific cost report data. The PPS rate varies by category and level of service intensity and is paid when a CCBH program delivers at least one (1) CCBHC covered service, and when a valid individual procedure code is reported for the calendar month. ~~Care coordination services do not trigger a PPS payment when billed alone in a calendar month.~~ For reimbursement purposes, members are categorized as follows, and are assigned to special populations by the State:

(1) Standard population;

(2) Special population 1. This population includes individuals eighteen (18) years of age and over with SMI and complex needs including those with co-occurring substance use disorder (SUD). Individuals between eighteen (18) and twenty-one (21) years of age can be served in either special population 1 or 2 depending on the member's individualized needs; and

(3) Special population 2. This population includes children and youth [ages six (6) through twenty-one (21)] with SED and complex needs, including those with co-occurring mental health and SUD.

~~(c) Payments for services provided to non-established clients will be separately billable. Non-established CCBH clients are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.~~

~~(d) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in~~

~~a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare fee schedule.~~

~~(e) Reimbursement rates will be reviewed bi-annually and updated as necessary by the Medicare Economic Index (MEI).~~

(c) Preliminary screening, risk assessment, and care coordination services are required activities to establish CCBHC members but do not trigger a PPS payment. An additional, qualifying service must be provided in the calendar month for the CCBHC to receive the PPS payment.

(d) Payments for services provided to non-established CCBHC members will be separately billable. Non-established CCBHC members are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and who are not established at another CCBHC, and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.

(e) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare fee schedule.

(f) Initial provider-specific rates are rebased after one (1) year based on actual cost and visit data. All other provider-specific rates are rebased once every two (2) years. Provider-specific rates are updated between rebasing periods based on the Medicare Economic Index (MEI).

(g) Providers may receive a provider-specific rate adjustment for changes in scope expected to change payment rates by two point five percent (2.5%) or more, once per year, subject to State approval in accordance with the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 6. OUT-OF-STATE SERVICES

317:30-3-92. ~~Payment for lodging and meals~~Lodging and meals services

~~(a) Payment for lodging and/or meals assistance for an eligible member and one (1) approved medical escort, if needed, is provided only when medically necessary in connection with SoonerCare compensable services. For medically necessary criteria please refer to Oklahoma Administrative Code 317:30-3-1 (f) (1) through (6). The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.~~

~~(1) Lodging and/or meals are reimbursable when prior approved. Payment for lodging and/or meals is limited to a period of up to twenty four (24) hours prior to the start of member's medical services and up to twenty four (24) hours after the services end. If travel arrangements cannot meet the aforementioned stipulations, due to travel issues/restrictions and/or medically necessary services, then lodging and/or meals may be provided with approval from the OHCA.~~

~~(2) Lodging and/or meals will not be provided if a suitable alternative is available at a hospital or non-profit. Factors to be considered in determining availability include, but are not limited to:~~

- ~~(A) Type of hospital room;~~
- ~~(B) Availability of "rooming in";~~
- ~~(C) Shower facilities available for use by the medical escort; and~~
- ~~(D) Member's anticipated length of stay.~~

~~(3) The following conditions must be met in order for lodging and/or meals to be reimbursed, unless the lodging and/or meals provision is determined to be the most cost effective alternative:~~

- ~~(A) Travel must be to obtain specialty care at the closest appropriate facility and be fifty (50) miles or greater from the member's home;~~
- ~~(B) The trip cannot be completed during SoonerRide operating hours or the member's medical treatment/condition requires an overnight stay; and~~
- ~~(C) Medical necessity must be confirmed and the medical escort must be actively engaged and participative in compensable care.~~

~~(4) Meals will be reimbursed if lodging criteria is met. Duration of the trip must be eighteen (18) hours or greater.~~

~~(5) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three (3) meals, as required. If meals or meal vouchers are provided by either the hospital or the lodging provider, additional reimbursement will not be provided to the member.~~

~~(6) During the first fourteen (14) days of a member's inpatient or outpatient stay, lodging and meals can be approved per a hospital social worker/provider without prior approval. Additional lodging and/or meals beyond the fourteen (14) days must be prior approved by the OHCA.~~

(7) A member may not receive reimbursement for lodging and/or meals services for days the member is inpatient in a hospital or medical facility since that will be provided at the location that the member is receiving inpatient services.

(b) ~~Criteria for lodging and/or meals reimbursement is as follows:~~

~~(1) Lodging must be with a SoonerCare contracted room and board provider, when available, before direct reimbursement to a member and/or medical escort can be authorized.~~

~~(2) If lodging and/or meals assistance with contracted room and board providers is not available, the member and any medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Population Care Management division.~~

~~(3) Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts. If the compensable service related to lodging/meals is not verifiable, reimbursement will be denied.~~

~~(4) Reimbursement for lodging will not exceed maximum state allowable amounts.~~

~~(5) In order for lodging to be reimbursed for a medical escort of a hospitalized member, the medical escort must be able to assist the member during escort and be of an age of legal majority recognized under state law. In cases where the lodging facility has additional requirements, the medical escort must comply with them. This includes, but is not limited to, being compliant with the lodging facility's required age to check in.~~

~~(c) If the Oklahoma Department of Human Services (DHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time, the temporary guardian is eligible for medical escort related lodging and/or meals services. If the minor is in need of medical services and a temporary guardian has not been appointed, then the DHS case worker accompanying the minor is eligible for lodging and/or meal services. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:~~

~~(1) When the individual's health or disability does not permit traveling alone; and~~

~~(2) When the individual seeking medical services is a minor child.~~

(a) Requests for lodging and meals services.

(1) Requests for lodging and meals services shall derive from the treating facility or the member. All requests shall be submitted at least three (3) business days prior to check-in, with exceptions made only in emergency situations. Requests will include, but are not limited to, the following information:

(A) SoonerCare member information:

(i) Name;

(ii) SoonerCare ID number;

(iii) Address;

(iv) Member diagnosis;

(B) Visit information:

(i) Inpatient/outpatient visit;

(ii) Facility name;

(iii) Provider name and number;

(iv) Appointment date and time:

(I) Check-in time;

(II) Duration of stay if inpatient;

(III) Admission date and time;

(C) Services requested:

- (i) Lodging;
- (ii) Meals; or
- (iii) Both lodging and meals;

(D) Medical escort information:

- (i) Name;
- (ii) Relationship to member;
- (iii) Medical necessity for the need of an escort; and

(E) Any special accommodations that need to be met.

(2) Any additional documentation, including medical records, that may be needed to determine the need for lodging and meals services.

(b) Meal requirements.

- (1) At least two (2) meals shall be provided/served to receive the per diem payment.
- (2) Meals provided shall strive to meet the nutritional guidance outlined in the current United States Department of Agriculture and Health and Human Services Dietary Guidelines.
- (3) Meals may be hot, cold, frozen, dried, or canned (with a satisfactory storage life).

(c) Reimbursement for lodging and meals services.

(1) Payment is made for lodging and/or meals assistance for an eligible member and one (1) approved medical escort, if needed, only when medically necessary and in connection with SoonerCare compensable services. For medically necessary criteria, please refer to Oklahoma Administrative Code 317:30-3-1 (f) (1) through (6). The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.

(A) Lodging and/or meals are reimbursable when prior approved. Payment for lodging and/or meals is limited to a period of up to twenty-four (24) hours prior to the start of member's medical service(s) and up to twenty-four (24) hours after the service(s) end. If travel arrangements cannot meet these timeframes, due to travel issues/restrictions and/or medically necessary services, then lodging and/or meals may be provided with approval from the OHCA.

(B) Lodging and/or meals will not be provided if a suitable alternative is available at a hospital or non-profit. Factors to be considered in determining availability include, but are not limited to:

- (i) Type of hospital room;
- (ii) Availability of "rooming-in";
- (iii) Shower facilities available for use by the medical escort; and
- (iv) Member's anticipated length of stay.

(C) The following conditions shall be met for lodging and/or meals to be reimbursed, unless the lodging and/or meals provision is determined to be the most cost-effective alternative:

- (i) Travel to obtain specialty care at the closest appropriate facility and be fifty (50) miles or greater from the member's home;
- (ii) The trip cannot be completed during SoonerRide operating hours or the member's medical treatment/condition requires an overnight stay; and
- (iii) Medical necessity is confirmed and the medical escort will be actively engaged and participative in compensable care.

(D) Meals will be reimbursed if lodging criteria is met. Duration of the trip must be eighteen (18) hours or greater.

(E) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch, or dinner, or all three (3) meals, as required.

(i) If meals or meal vouchers are provided by either the hospital or the lodging provider, additional reimbursement will not be provided to the member.

(ii) If meals or meal vouchers are not provided by either the hospital or lodging provider, the member may be reimbursed for getting meals outside of the hospital or lodging provider. In lieu of meals out, groceries may be reimbursed up to the daily per diem limit.

(iii) If meals or meal vouchers are provided by the lodging provider, but the member has a medically indicated dietary need that the lodging provider would not meet on a normal basis, the member may provide their own meals and be reimbursed.

(I) Members will be reimbursed based on the daily per diem rate. In lieu of meals out, groceries may be reimbursed up to the daily per diem limit.

(II) Medical documentation showing medically necessary dietary needs will need to be provided upon request for these circumstances.

(III) If varying dietary preferences need to be accommodated, that will be at the member's own expense.

(F) During the first fourteen (14) days of a member's inpatient stay, lodging and meals can be approved per a hospital social worker/provider without prior approval. Additional lodging and/or meals beyond the fourteen (14) days must be prior approved by the OHCA.

(G) A member may not receive reimbursement for lodging and/or meals services for days the member is inpatient in a hospital or medical facility since that will be provided at the location that the member is receiving inpatient services.

(2) Criteria for lodging and/or meals reimbursement is as follows:

(A) If lodging and/or meals assistance with contracted room and board providers is not available, the member and the medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting the SoonerCare Population Care Management division.

(B) Any lodging and/or meal expenses claimed on the travel reimbursement forms shall be documented with the required receipts. If the compensable service related to lodging/meals is not verifiable, reimbursement will be denied.

(C) Reimbursement for lodging will not exceed maximum State allowable amounts.

(D) In order for lodging to be reimbursed for a medical escort of a hospitalized member, the medical escort is required to actively assist the member during the escort and be of an age of legal majority recognized under State law. In cases where the lodging facility has additional requirements, the medical escort shall comply with them. This includes, but is not limited to, being compliant with the lodging facility's required age to check in.

(E) The lodging provider is not eligible for reimbursement if the member and/or approved medical escort do not stay overnight. If the member and/or escort do not remove personal belongings, the lodging provider may charge the member and/or medical escort for the room that is occupied.

(d) Authorizations and verification of services.

- (1) The member and/or medical escort shall review and sign an appropriate attestation, from the lodging provider, verifying the correct dates are listed in the length of stay.
- (2) The member and/or medical escort are responsible for notifying the lodging provider, and the OHCA, if they do not stay overnight or if they leave earlier than the days that have been allotted on the authorization. If the member and/or medical escort do not stay overnight, or leave early, the appropriate attestation shall still need to be reviewed, verified, and signed.
- (3) The member and/or approved medical escort may be required to sign in/out at the lodging provider's front desk on a daily basis.

(e) Incidental charges, damages, and complaints.

(1) Incidental charges and damages.

(A) Any incidental charges, including costs and services that are not covered under the lodging and meals benefit, will not be paid. If the member and/or medical escort makes any charges outside the scope of the lodging and meals benefit, then the member and/or medical escort shall be responsible for the charges incurred.

(B) The member, and/or approved medical escort, shall be responsible for the payment of any damages that are made to the lodging facility.

(2) Complaints on members/medical escorts.

(A) If a complaint is received from the lodging provider on a member and/or approved medical escort, the OHCA will reassign the member and/or approved medical escort to another lodging facility.

(B) If the OHCA receives more than two (2) complaints on the member and/or medical escort, then the member and/or medical escort will be moved to a probationary period. During the probationary period, the member and/or medical escort will be required to provide his, her, or their own lodging which will be eligible for reimbursement up to the daily per diem rate.

(3) Complaints on providers/lodging facilities.

(A) Any complaints on lodging facilities should be directed to the SoonerCare Population Care Management division. The member should provide as much information as possible, including but not limited to, the time, facility, names, and the exact nature of the complaint.

(B) If the complaint is a safety issue, then the OHCA will assist the member into getting placed with another lodging provider, if available, or make arrangements for lodging reimbursement.

(C) The OHCA will gather all pertinent information and document it into the system to see if there are any ongoing trends with the lodging providers who have had complaints filed on them. The OHCA will use this information to attempt to decrease the likelihood of issue reoccurrences.

(D) If complaints/issues continue to persist, the OHCA will work with the lodging facility and the Oklahoma State Department of Health (OSDH) to create an appropriate solution.

(f) Temporary guardians.

(1) If the Oklahoma Department of Human Services (DHS) removes a child from his/her/their home, a court must appoint a temporary guardian. During this time, the temporary guardian is eligible for medical escort-related lodging and/or meals services. If the minor is in need of medical services and a temporary guardian has not been appointed, then the DHS case worker accompanying the minor is eligible for lodging and/or meal services.

(2) It is the responsibility of the OHCA to determine this necessity. The decision will be based on the following circumstances:

(A) When the individual's health or disability does not permit traveling alone; and

(B) When the individual seeking medical services is a minor child.

(g) **Clinical trials.** In accordance with federal regulations and OAC 317:30-3-57.1 and 317:30-3-90 (d)(2), exceptions to the lodging and meals prior authorization requirements will be made for members who are participating in a clinical trial that requires the member to go out-of-state.

(h) **Final authority.** The OHCA has discretion and the final authority in determining the need for lodging and meals, as well as who will be providing the lodging and meals services. This includes the mode of provision for the services, whether it be through a SoonerCare contracted provider or direct reimbursement to a member or a medical escort.

DRAFT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 62. PRIVATE DUTY NURSING

317:30-5-555. Private Duty Nursing (PDN)

PDN is medically necessary care provided on a regular basis by a licensed practical nurse or registered nurse. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility. PDN services are provided:

(1) In the member's primary residence, unless it is medically necessary for a nurse to accompany the individual in the community.

(A) The individual's place of residence is wherever the individual lives, whether the residence is the individual's own dwelling, a relative's home, or other type of living arrangement. The place of residence cannot include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(B) The place of service in the community cannot include the residence or business location of the provider of PDN services unless the provider of PDN is a live-in caregiver.

(2) To assist during transportation to routine, Medicaid-compensable health care appointments and/or to the nearest appropriate emergency room, ~~but only when SoonerRide is unavailable, and a lack of PDN services during transportation would require transportation by ambulance pursuant to Oklahoma Administrative Code (OAC) 317:30-5-336.~~

(A) The private duty nurse may not drive the vehicle during transportation.

(B) PDN services are not available for non-routine extended home absences unrelated to medically necessary treatment or medical care. [Refer to Oklahoma Administrative Code 317:30-5-558(4)_and_(13)].

317:30-5-557. Coverage by category

(a) **Adults.** ~~SoonerCare does not cover adults (Age 21 or over)~~twenty-one (21) years of age and over for private duty nursing (PDN) with the exception of subsection (c).

(b) **Children.** ~~SoonerCare does cover children (Under the age of 21)~~under twenty-one (21) years of age if:

(1) ~~the~~The child member is eligible for SoonerCare; and

(2) ~~the~~The Oklahoma Health Care Authority (OHCA), in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-560.1.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the SoonerCare allowable for comparable services.

(d) 1915(c) home and community-based services (HCBS) waivers. If private duty nursing services are provided, they will be defined within each waiver and must be prior authorized.

317:30-5-558. Private duty nursing (PDN) coverage limitations

The following provisions apply to all PDN services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA). Prior authorization means authorization in advance of services provided in accordance with Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-560.1;

(2) A treatment plan must be completed by ~~the home health agency~~ an eligible PDN provider before requesting prior authorization and must be updated at least annually and signed by the physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN)];

(3) ~~A telephonic interview and/or personal visit by an OHCA care management nurse is required prior to the authorization for services~~ An assessment by an OHCA care management nurse is required prior to the authorization for services. The assessment will be conducted by the OHCA through one (1) of the following:

(A) Telephone;

(B) Virtually; or

(C) Face-to-face;

(4) Care in excess of the designated hours per day granted in the prior authorization is not SoonerCare compensable. Prior-authorized but unused service hours cannot be "banked," "saved," or otherwise "accumulated" for use at a future date or time. If such hours or services are provided, they are not SoonerCare compensable.

(5) Any medically necessary PDN care provided outside of the home must be counted in and cannot exceed the number of hours requested on the treatment plan and approved by OHCA.

(6) PDN services do not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will OHCA compensate an organization for nursing staff time when sleeping.

(8) OHCA will not approve PDN services if all health and safety issues cannot be met in the setting in which services are provided.

(9) A provider must not misrepresent or omit facts in a treatment plan.

(10) It is outside the scope of coverage to deliver care in a manner outside of the treatment plan or to deliver units over the authorized units of care.

(11) PDN is not authorized in excess of sixteen (16) hours per day. There may be approval for additional hours for a period not to exceed thirty (30) days, if:

(A) The member has an acute episode that would otherwise require hospitalization or immediately following a hospital stay; or

(B) The primary caregiver is temporarily and involuntarily unable to provide care.

(C) The OHCA has discretion and the final authority to approve or deny any additional PDN hours and will take into consideration that the additional hours are not to be a substitute for institutionalized care.

(12) Family and/or caregivers and/or guardians (hereinafter, "caregivers") are required to provide some of the nursing care to the member without compensation. PDN services shall not be provided solely to allow the member's caregiver to work or go to school, nor solely to allow respite for the caregiver.

(13) PDN services will not be approved for overnight trips away from the member's primary residence that are unrelated to medically necessary treatment or medical care.

(A) For a member to receive Medicaid-reimbursable PDN services on an overnight trip that is related to medically necessary treatment or medical care, all provisions of this Part must be met. If said trip occurs out of state, OAC 317:30-3-89 through 317:30-3-92 must also be met.

(B) In instances in which the member's family is temporarily absent due to vacations, any additional PDN hours must be paid for by the family, or provided by other trained family members without SoonerCare reimbursement.

(14) PDN services will not be approved when services are reimbursed or reimbursable by other insurance, other governmental programs, or Medicaid program services that the member receives or is eligible to receive. For example, if a member receives Medicaid-reimbursable PDN services pursuant to an Individualized Education Program (IEP) in a public school, then those PDN school hours will be counted in the member's daily allotment of PDN services.

317:30-5-559. ~~How services are authorized~~How Private Duty Nursing (PDN) services are authorized

~~An eligible provider may have private duty nursing services authorized by following all the following steps:~~

- ~~(1) create a treatment plan for the patient as expressed in OAC 317:30-5-560;~~
- ~~(2) submit the prior authorization request with the appropriate OHCA required forms, the treatment plan, and request the telephonic interview and/or personal visit by an OHCA Care Management Nurse; and~~
- ~~(3) have an OHCA physician determine medical necessity of the service including scoring the member's needs on the Private Duty Nursing Acuity Grid.~~

~~PDN services may be initiated after completion of the following steps:~~

- (1) A treatment plan for the patient has been created by an eligible PDN provider per Oklahoma Administrative Code (OAC) 317:30-5-560;
- (2) A prior authorization request is submitted with the appropriate Oklahoma Health Care Authority (OHCA) required data elements and the treatment plan;
- (3) An assessment (telephonic, virtual, or face-to-face) has been conducted by an OHCA care management nurse, per OAC 317:30-5-558 (3); and
- (4) An OHCA physician has determined the medical necessity of the service, including but not limited to, scoring the member's needs on the OHCA PDN assessment.

317:30-5-560. Treatment Plan

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing (PDN) services. The initial treatment plan must be signed by the member's attending physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN).

~~(b) The treatment plan must include all of the following medical and social data so that an OHCA physician can appropriately determine medical necessity including use of the Private Duty Nursing Acuity Grid:~~

- ~~(1) diagnosisDiagnosis;~~
- ~~(2) prognosisPrognosis;~~
- ~~(3) anticipatedAnticipated length of treatment;~~
- ~~(4) numberNumber of hours of private duty nursingPDN requested hours requested per day;~~
- ~~(5) assessmentAssessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory);~~
- ~~(6) medicationMedication method of administration and frequency;~~
- ~~(7) age-appropriateAge-appropriate feeding requirements (diet, method and frequency);~~
- ~~(8) respiratoryRespiratory needs;~~
- ~~(9) mobilityMobility requirements including need for turning and positioning, and the potential for skin breakdown;~~

- (10) ~~developmental~~Developmental deficits;
- (11) ~~easting~~Casting, orthotics, therapies;
- (12) ~~age-appropriate~~Age-appropriate elimination needs;
- (13) ~~seizure~~Seizure activity and precautions;
- (14) ~~age-appropriate~~Age-appropriate sleep patterns;
- (15) ~~disorientation~~Disorientation and/or combative issues;
- (16) ~~age-appropriate~~Age-appropriate wound care and/or personal care;
- (17) ~~communication~~Communication issues;
- (18) ~~social~~Social support needs;
- (19) ~~name~~Name, skill level, and availability of all caregivers; and
- (20) ~~other~~Other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

- (a) Authorizations are provided for a maximum period of six (6) months.
- (b) Authorizations require:
 - (1) ~~a~~An treatment plan for the member;
 - (2) ~~a telephonic interview and/or personal visit by an OHCA Care Management Nurse~~An assessment (telephonic, virtual, or face-to-face) has been conducted by an Oklahoma Health Care Authority (OHCA) care management nurse, per Oklahoma Administrative Code (OAC) 317:30-5-558 (2); and
 - (3) ~~an~~An OHCA physician to determine medical necessity including use of the ~~Private Duty Nursing Acuity Grid~~OHCA Private Duty Nursing (PDN) assessment.
- (c) The number of hours authorized may differ from the hours requested on the treatment plan based on the review by an OHCA physician.
- (d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.
- (e) Changes in the treatment plan may necessitate another ~~telephonic interview and/or personal visit by the OHCA Care Management staff~~assessment (telephonic, virtual, or face-to-face) by an OHCA care management nurse.

317:30-5-560.2. Record documentation

~~The treatment plan must be updated and signed by the attending physician at least annually. Copies of the attending physician's orders and, at a minimum, the last 30 days of medical records for the actual care provided must be maintained in the home. Medical records must include the beginning and ending time of the care and must be signed by the person providing care. The nurse's credentials must also be included. All provisions of the treatment plan, such as vital signs, medication administration, glucose/neuro checks, vital signs, respiratory assessments, and all applicable treatments must be documented in the record. All records must meet the requirements set forth in OAC 317:30-3-15.~~

- (a) The treatment plan must be updated and signed by the attending physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN) at least annually.
- (b) Copies of the attending physician's orders and, at a minimum, the last thirty (30) days of medical records for the actual care provided must be maintained and include the following:
 - (1) The beginning and ending time of the care and must be signed by the person providing care;
 - (2) The nurse's credentials;

(3) All provisions of the treatment plan, such as vital signs, medication administration, glucose/neuro checks, vital signs, respiratory assessments, and all applicable treatments must be documented; and

(4) Meet the record retention requirements set forth in Oklahoma Administrative Code (OAC) 317:30-3-15.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

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

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

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

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

- (i) ~~An oral examination;~~Oral examinations;
- (ii) ~~Bite-wing X-rays;~~Medically necessary images;
- (iii) ~~Dental cleaning;~~Prophylaxis;
- (iv) ~~Topical fluoride treatment;~~Fluoride application;
- (v) Development of a sequenced treatment plan that prioritizes:
 - (I) ~~Elimination of pain;~~Pain elimination;
 - (II) Adequate oral hygiene; and
 - (III) ~~Restoration or an improved~~Restoring or improving ability to chew;
- (vi) Routine training of member or primary caregiver regarding oral hygiene; and
- (vii) Preventive, restorative, replacement, and repair services to achieve or restore functionality provided after appropriate review when applicable, per OAC 317:40-5-112.

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

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

(3) **Occupational therapy services.**

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

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

(i) Services are:

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

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

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

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

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

(4) **Physical therapy services.**

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

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

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

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

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

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification ~~as a provider of~~to provide psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists, or by the licensing board in the state ~~in~~ whichwhere the service is provided. Psychological technicians who have completed all

board certification and training requirements may provide services under a licensed psychologist's supervision.

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

(i) Services are:

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

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

(ii) ~~Approval of services~~Service approval is based ~~upon~~on assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

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

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

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

(II) Authorizations may not exceed two hundred and eighty-eight (288) units per ~~plan of care~~POC year unless the DDS Behavior Support Services director or designee makes an exception ~~is made by the DDS director of Behavior Support Services or his or her designee~~.

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

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

(6) **Psychiatric services.**

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

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

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

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

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

(200) units, per ~~Plan of Care~~POC year.

(7) Speech-language pathology services.

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

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

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

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

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

(8) Habilitation training specialist (HTS) services.

(A) **Minimum qualifications.** Providers ~~must complete the Oklahoma Department of Human Services (DHS)~~(OKDHS) DDS-sanctioned training curriculum. Residential habilitation providers:

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

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

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

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

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

(i) Payment is not made for:

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

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

(ii) Family members who provide HTS services ~~must~~ meet the same standards as

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

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

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

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

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

(I) Provider receives DDS area staff oversight; and

(II) ~~Must be~~ is pre-approved by the DDS director or his or her designee.

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

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

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

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

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

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

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

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

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

~~(10)~~ (11) Self Directed Goods and Services (SD GS). SD GS are provided per OAC 317:40-9-1.

~~(11)~~ (12) Audiology services.

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

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

(i) The member's IP ~~must include~~ includes a practitioner's prescription. For this Section's purposes ~~of this Section~~, practitioners are defined as licensed medical and

osteopathic physicians, and physician assistants in accordance with ~~rules and regulations~~ OAC 317:30-5-1 covering the OHCA SoonerCare program.

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

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

~~(12)~~(13) **Prevocational services.**

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

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

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

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

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

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

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

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

(iii) Pre-vocational services are delivered ~~for the purpose of furthering~~ to further habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation ~~must be~~ is maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) Services include:

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

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

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

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

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed \$27,000, ~~per Plan of Care year.~~ the annual costs set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. The services that may not be provided to the same member at the same time as prevocational services are:

- (i) HTS;
- (ii) ~~Intensive Personal Supports; IPS;~~
- (iii) Adult Day Services;
- (iv) Daily Living Supports; (DLS);
- (v) Homemaker; or
- (vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services; family counseling; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, per OAC 317:40-7-6.

~~(13)~~**(14) Supported employment.**

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

- (i) Are ~~at least~~ eighteen (18) years of age; ~~or older;~~
- (ii) Complete the ~~DHS~~OKDHS DDS-sanctioned training curriculum;
- (iii) ~~Were~~Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.5; and
- (iv) Receive supervision and oversight ~~by~~from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

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

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

- (I) Is made for the adaptations, supervision, and training ~~required by members~~ require as a result of their disabilities; and
- (II) Does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

- (I) Job coaching per OAC 317:40-7-7;
- (II) Enhanced job coaching per OAC 317:40-7-12;
- (III) Employment training specialist services per OAC 317:40-7-8; and
- (IV) Stabilization per OAC 317:40-7-11.

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

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

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

- (I) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
- (II) Payments passed through to users of supported-employment programs; or
- (III) Payments for vocational training not directly related to a member's supported-employment program.

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

- (i) HTS;
- (ii) ~~Intensive Personal Supports;~~ IPS;
- (iii) Adult Day Services;
- (iv) ~~Daily Living Supports;~~ DLS;
- (v) Homemaker; or
- (vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

~~(14)~~(15) **~~Intensive personal supports (IPS)~~-IPS.**

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

- (i) Are ~~at least~~ eighteen (18) years of age; or older;
- (ii) Complete ~~the DHS~~OKDHS DDS-sanctioned training curriculum;
- (iii) ~~Were~~Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.2;
- (iv) Receive supervision and oversight ~~by~~from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities; and
- (v) Receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **~~Description of services~~.Service description.**

- (i) IPS:
 - (I) Are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and
 - (II) Build ~~upon~~on the support level of ~~support provided by a HTS or daily living supports (DLS)~~DLS staff provides by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational and habilitation activities.
- (ii) The member's ~~Individual Plan (IP)~~ IP clearly ~~specify~~specifies the role of HTS and the person providing IPS to ensure there is no service duplication ~~of services~~.

~~(iii) Review and approval by the DDS plan of care reviewer is required. The DDS POC reviewer is required to review and approve services.~~

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

~~(15)~~(16) **Adult day services.**

(A) **Minimum qualifications.** Adult day ~~services~~service provider agencies ~~must~~:

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

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

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

(C) **Coverage limitations.** Adult day services are furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. A unit is fifteen (15) minutes for up to a maximum of six (6) hours daily, at which point a unit is one (1) day. All services ~~must be~~are authorized in the member's IP.

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**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES**

SUBCHAPTER 5. MEMBER SERVICES

PART 1. AGENCY COMPANION SERVICES

317:40-5-5. Agency companion services (ACS) provider requirements and responsibilities

~~(a) Companions are required to meet all applicable standards outlined in this subchapter and competency-based training per Oklahoma Administrative Code (OAC) 340:100-3-38. The provider agency ensures all companions meet the criteria in this Section. The member or legal guardian, the provider agency, or Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) case manager may identify an applicant to be screened for approval to serve as a companion.~~

~~(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, per OAC 340:100-3-27, for the companion, and when warranted, revocation of approval of the companion. DDS approval for a person to provide contracted Agency Companion Services (ACS) requires the applicant to:~~

~~(1) Be twenty-one (21) years of age or older;~~

~~(2) Attend DDS or provider agency ACS orientation;~~

~~(3) Contract with a provider agency that has a current contract with Oklahoma Health Care Authority (OHCA) to provide ACS;~~

~~(4) Complete the DDS application packet within the required time period, per Oklahoma Administrative Code (OAC) 317:40-5-40, and to submit the packet to designated DDS staff or the provider agency staff;~~

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

~~(6) Complete all training per OAC 340:100-3-38, including medication administration training, and all provider agency pre-employment training, per OAC 317:40-5-40.~~

~~(c) The companion:~~

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

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

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

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

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

~~(6) Develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Plan. The~~

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

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

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

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

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

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

~~(A) Traveling out of state;~~

~~(B) Overnight visits; or~~

~~(C) Involvement of the member in any publicity;~~

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

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

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

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

~~(16) Assist the member to achieve the member's maximum level of independence;~~

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

~~(18) Ensures the member's confidentiality is maintained per, OAC 340:100-3-2;~~

~~(19) Supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;~~

~~(20) Implements training and provides supports that enable the member to actively join in community life;~~

~~(21) Does not serve as representative payee for the member without a written exception from the DDS area residential services programs manager or state office residential services program manager.~~

~~(A) The written exception and approved DDS home profile are retained in the member's home record.~~

~~(B) When serving as payee, the companion complies with OAC 340:100-3-4 requirements;~~

~~(22) Ensures the member's funds are properly safeguarded;~~

~~(23) Obtains prior approval from the member's representative payee when making a purchase of over fifty dollars (\$50) with the member's funds;~~

~~(24) Allows provider agency and DDS staff to make announced and unannounced visits to the home;~~

~~(25) Develops an Evacuation Plan, using (OKDHS) Form 06AC020E, Evacuation/Escape~~

Plan, for the home and conducts training with the member;

~~(26) Conducts fire and weather drills at least quarterly and documents the fire and weather drills using OKDHS Form 06AC021E, Fire and Weather Drill Record;~~

~~(27) Develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using OKDHS Form 06AC022E, Personal Possession Inventory;~~

~~(28) Supports the member's employment program by:~~

~~(A) Assisting the member to wear appropriate work attire; and~~

~~(B) Contacting the member's employer as outlined by the Team and in the Plan;~~

~~(29) Is responsible for the cost of the member's meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution;~~

~~(30) For adults, reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes, to the OKDHS Office of Client Advocacy (OCA);~~

~~(31) For children, reports abuse, neglect, sexual abuse, or sexual exploitation per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Child Abuse and Neglect Hotline at 1-800-522-3511;~~

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

~~(A) OAC 340:100-3-27;~~

~~(B) OAC 340:100-3-34;~~

~~(C) OAC 340:100-3-38;~~

~~(D) OAC 340:100-3-40;~~

~~(E) OAC 340:100-5-22.1;~~

~~(F) OAC 340:100-5-26;~~

~~(G) OAC 340:100-5-32;~~

~~(H) OAC 340:100-5-33; and~~

~~(I) OAC 340:100-5-50 through 340:100-5-58.~~

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

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

(c) Companions are required to meet all applicable standards outlined in this subchapter and competency-based training, per OAC 340:100-3-38. The provider agency ensures all companions meet the criteria in this Section.

(d) The companion's failure to follow any rules or standards, promote the member's independence, or follow the Personal Support Team's (Team) recommendation(s) results in problem resolution, per OAC 340:100-3-27, for the companion, and when warranted, results in revocation of approval of the companion.

(e) The companion:

(1) Ensures no other adult or child is cared for in the home on a regular or part-time basis, including other OKDHS placements, family members, or friends without prior written authorization from DDS area residential services programs manager or state office residential services programs manager;

(2) Meets transportation requirements per OAC 317:40-5-103. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

- (3) Transports or arranges member transportation to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;
- (4) Delivers services in a manner that contributes to the member's enhanced independence, self-sufficiency, community inclusion, and well-being;
- (5) Participates in the member's Team and assists in developing the member's Individual Plan (Plan) for service provision;
- (6) Develops, implements, evaluates, and revises training strategies that correspond to the Plan's relevant outcomes. The companion may request assistance from the case manager or program coordinator. The companion documents monthly data and health care summaries and submits them to the provider agency program coordination staff;
- (7) Delivers services at appropriate times as directed in the Plan;
- (8) Does not deliver services that duplicate the services public school districts provide pursuant to the Individuals with Disabilities Education Act (IDEA);
- (9) Respects the member's chosen religious faith and assists the member in religious participation. No member is expected to attend any religious service against his or her wishes;
- (10) Participates in, and supports visitation and contact with, the member's natural family, guardian, and friends, when the member desires visitation;
- (11) Obtains permission from the member's assigned legal guardian and notifies the family, the provider agency program coordination staff, and the case manager prior to:
 - (A) Traveling out-of-state;
 - (B) Overnight visits; or
 - (C) The member's involvement in any publicity, including the following: advertising, promotions, marketing campaigns, or involvement with the media;
- (12) Serves as the member's health care coordinator, per OAC 340:100-5-26;
- (13) Ensures the member's monthly room and board contribution is used toward household operation costs;
- (14) Assist the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;
- (15) Works closely with the provider agency program coordination staff and the DDS case manager, to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;
- (16) Assist the member to achieve his or her maximum level of independence;
- (17) Submits all necessary information regarding the member to the provider agency program coordination staff in a timely manner;
- (18) Ensures the member's confidentiality is maintained per, OAC 340:100-3-2;
- (19) Supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
- (20) Implements training and provides supports that enable the member to actively join in community life;
- (21) Does not serve as the member's representative payee without a written exception from the DDS area residential services programs manager or state office residential services program manager.
 - (A) The written exception and approved DDS home profile are retained in the member's home record.

(B) When serving as payee, the companion complies with OAC 340:100-3-4 requirements;

(22) Ensures the member's funds are safeguarded;

(23) Obtains prior approval from the member's representative payee when making a purchase of over fifty dollars (\$50) with the member's funds;

(24) Allows provider agency and DDS staff to make announced and unannounced visits to the home;

(25) Develops an evacuation plan for the home using OKDHS Form 06AC020E, Evacuation/Escape Plan, and conducts training with the member;

(26) Conducts fire and weather drills, per OAC 340:100-5-22.1, using OKDHS Form 06AC021E, Fire and Weather Drill Record;

(27) Develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using OKDHS Form 06AC022E, Personal Possession Inventory;

(28) Supports the member's employment program by:

(A) Ensuring the member wears appropriate work attire; and

(B) Contacting the member's employer as outlined by the Team and in the Plan;

(29) Is responsible for the member's meals and entertainment costs during recreational and leisure activities. Activities are affordable to the member. Concerns about affordability are presented to the Team for resolution;

(30) For vulnerable adults, reports of suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, or exploitation, per Section 10-104 of Title 43A of the Oklahoma Statutes (43A O.S. § 10 - 104), are submitted to OKDHS Office of Client Advocacy;

(31) For children, reports of abuse, neglect, sexual abuse, or sexual exploitation, per 10A O.S. § 1-2-101, are submitted to the Child Abuse and Neglect Hotline at 1-800-522-3511;

(32) Follows all applicable promulgated OHCA and DDS rules including:

(A) OAC 340:100-3-27;

(B) OAC 340:100-3-34;

(C) OAC 340:100-3-38;

(D) OAC 340:100-3-40;

(E) OAC 340:100-5-22.1;

(F) OAC 340:100-5-26;

(G) OAC 340:100-5-32;

(H) OAC 340:100-5-33; and

(I) OAC 340:100-5-50 through 340:100-5-58.

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

(34) Is not the chief executive officer of a provider agency.

317:40-5-6. Agency Companion contractor requirements [REVOKED]

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

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

- (1) is 21 years of age or older;
- (2) has attended the DDS or provider agency ACS orientation;
- (3) contracts with a provider agency having a current contract with the Oklahoma Health Care Authority to provide ACS;
- (4) submits the completed DDS application packet per Oklahoma Administrative Code (OAC) 317:40-5-40 within the required time period to designated DDS staff or the provider agency staff;
- (5) cooperates with designated DDS or provider agency staff in the development and completion of the home profile approval process per OAC 317:40-5-40; and
- (6) has completed all training required by OAC 340:100-3-38, including medication administration training, and all provider agency pre-employment training per OAC 317:40-5-40.

SUBCHAPTER 3. GUIDELINES TO STAFF

317:40-5-40. Home profile process ~~1 & 2~~

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

- (1) Agency companion services (ACS);
- (2) Specialized ~~Foster care~~ Foster Care (SFC) services;
- (3) Respite services delivered in the provider's home;
- (4) Approving services in a home shared by a non-relative provider and a member; and
- (5) Any other situation that requires a home profile.

(b) **Pre-screening.** Designated DDS staff provides the applicant with program orientation and completes pre-screening activities ~~to~~ that include, but are not limited to:

- (1) Facts description, ~~and guiding principles of the Home and Community-Based Services (HCBS) program;~~
- (2) An explanation of:
 - (A) Home and Community-Based Services (HCBS) program's guiding principles;
 - ~~(A)~~(B) The home profile process;
 - ~~(B)~~(C) Basic provider qualifications;
 - ~~(C)~~(D) Health, safety, and environmental issues; and
 - ~~(D)~~(E) Training required per Oklahoma Administrative Code (OAC) 340:100-3-38; and
- (3) Gathering relevant information about the applicant and applicant's family, including household members, addresses, ~~and~~ contact information, and motivation to provide services; and
- (4) An explanation of the background investigation that is conducted on the applicant and on any adult or child living in the applicant's home.
 - (A) Background investigations are conducted at the time of application and include, but are not limited to:
 - (i) An Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search, including the Oklahoma Department of Public Safety ~~(DPS)~~, Sex Offender Registry, Mary Rippy Violent Offender Registries, and Nurse Aide and Non-technical Services Worker Registry;
 - (ii) Federal Bureau of Investigation (FBI) national criminal history search, which is based on the applicant's fingerprints ~~of the applicant and any adult members of the~~

~~household;~~ household member's fingerprints; except when an exception is necessary as outlined ~~below~~, in (I) through (II) of this subsection.

(I) When fingerprints are low quality, ~~(as determined by OSBI, FBI, or both)~~ as determined by OSBI, FBI, or both, and make it impossible for the national crime information databases to provide results, In this instance, a name-based search, ~~(state, national, or both)~~ state, national, or both, may be authorized.

(II) When the DDS State Office residential staff ~~request~~ requests an exception from an individual, who has a severe physical condition precluding the individual from being fingerprinted, a name-based search, ~~(state, national, or both)~~ state, national, or both may be authorized.

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

(iv) ~~Search~~ A search of all OKDHS records, including Child Welfare Services records, Community Services Worker Registry, and Restricted Registry;

(v) A search of all applicable out-of-state child abuse and neglect registries for any applicant or adult household member who has not lived in Oklahoma continuously for the past five (5) years. A home is not approved without the results ~~of the out-of-state child abuse and neglect registry checks, when a registry is maintained in the applicable state,~~ out-of-state child abuse and neglect registry check for all adult household members living in the home. When a child abuse and neglect registry is not maintained in the applicable state, an information request for information is made to the applicable state; and

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

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

(i) Has a criminal conviction of, or pled guilty or no contest to:

(I) Physical assault, battery, or a drug-related offense in the ~~five-year~~ five(5) year period preceding the application date;

(II) Child abuse or neglect;

(III) Domestic abuse;

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

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

(ii) Does not meet OAC 340:100-3-39 requirements;

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

(1) The applicant provides required information for ~~the~~ home profile completion ~~of the home profile.~~

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

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

- (4) For each reference ~~provided by the applicant;~~ provides, designated DDS staff documents the completed reference check results of each completed reference check.
- (5) Designated DDS staff, through interviews, visits, and phone calls, gathers information required to complete the home profile.
- (6) DDS staff review policies and responsibility areas of responsibilities with the applicant and ~~acknowledgment is made in writing by the applicant and designated DDS staff.~~ DDS staff and the applicant acknowledge the review in writing.
- (7) The DDS ~~area residential services~~ area residential services programs manager sends to the applicant:
- (A) A provider approval letter confirming the applicant is approved to serve as a provider; or
 - (B) A denial letter stating the application and home profile are denied.
- (8) DDS staff records the completion dates of completion of each part of the home profile process.
- (d) **Home standards.** In order to qualify and remain in compliance, the applicant's or provider's home must meet the provisions in (1) through (11) of this subsection.
- (1) **General conditions.**
- (A) The home, buildings, and furnishings ~~must be~~ are comfortable, clean, and in good repair, and the grounds ~~must be~~ are maintained. There ~~must be~~ is no ~~accumulation of accumulating~~ garbage, debris, or rubbish or offensive odors.
 - (B) The home must:
 - (i) Be accessible to school, employment, church, day programming, recreational activities, health facilities, and other community resources as needed;
 - (ii) Have adequate heating, cooling, and plumbing; ~~and~~
 - (iii) Provide space for the member's personal possessions and privacy; and
 - (iv) Allow adequate space for the occupants' recreational and social needs ~~of the occupants.~~
 - (C) Provisions for the member's safety ~~must be~~ are present, as needed, including:
 - (i) Guards and rails on stairways;
 - (ii) Wheelchair ramps;
 - (iii) Widened doorways;
 - (iv) Grab bars;
 - (v) Appropriate lifting equipment as needed for safe transfers;
 - (vi) Access to safe bathing and toileting;
 - ~~(vii)~~ (vii) Adequate lighting;
 - ~~(viii)~~ (viii) Anti-scald devices; and
 - ~~(ix)~~ (ix) Heat and air conditioning equipment guarded and installed in accordance with manufacturer requirements. Home modifications and equipment may be provided through HCBS Waivers operated by DDS.
 - (D) Providers must not permit members to access or use swimming or other pools, hot tubs, saunas, ponds, or spas on the premises without supervision. Swimming pools, hot tubs, saunas, ponds, or spas ~~must be~~ are equipped with sufficient safety barriers or devices designed to prevent accidental injury or unsupervised access.
 - (E) The household ~~must be~~ is covered by homeowner's or renter's insurance including personal liability insurance.
- (2) **Sanitation.**

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

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

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

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

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

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

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

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

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

(3) Bathrooms. A bathroom must:

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

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

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

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

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

(iii) There must be at least one (1) toilet, one (1) sink, and one (1) bathtub or shower for every six (6) household occupants, including the provider and family.

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

(A) ~~Have~~ Has been constructed ~~as such~~ for that purpose when the home was built or remodeled under permit;

(B) ~~Be~~ Is provided for each member.

~~(i) Exception~~ The DDS are residential services program manager may make exceptions to allow members to share a bedroom may be made by DDS area residential program manager, when DDS determines sharing a bedroom is in the members' best interest of the member interests.

(ii) A member must not share a bedroom with more than one (1) other ~~person;~~ member;

(iii) Minor members must not share bedrooms with ~~adults.~~ an adult member. Exceptions may be approved by the DDS Area Field Administrator when (I) through (III) of this section are met. Additional exceptions to these rules may be approved by the division director or designee:

(I) The minor is at least sixteen (16) years of age;

(II) The adult member does not present a risk of harm to the minor; and

(III) The members are sharing a room at the time the older member turns eighteen (18) years of age;

(C) ~~Have~~Has two (2) means of egress and a minimum of eighty (80) square feet of usable floor space for each member or one-hundred and twenty (120) square feet for two (2) members ~~and two (2) means of egress~~. The home's provider, family members, or other occupants ~~of the home~~ must not sleep in areas designated as common use living areas, nor share bedrooms with members;

(i) Exceptions to allow non-members and members to share a bedroom may be approved by the Division Director or designee when:

(I) The member agrees and the agreement is documented in the IP annually;

(II) Neither the member nor the non-member are determined to be at risk or harm; and

(III) Neither the member nor the non-member are eighteen (18) years or older; and

(ii) Consideration is given to age, gender, support needs, behavioral health needs, number of restrooms available in the home, and total household square footage.

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

(E) ~~Be~~Is adequately ventilated, heated, cooled, and lighted;

(F) ~~Include~~Includes an individual bed for each member consisting of a frame, box spring, when other support is not included in the frame, and a mattress at least thirty-six (36) inches wide, unless a specialized bed is required to meet identified needs. ~~Cots, rollaways, rollaway beds, couches, futons, air mattresses, and folding beds must not be~~ are not used for members. The division director or designee may make exceptions for temporary respite when the Personal Support Team (Team) is able to demonstrate that privacy can be maintained.

(i) Each bed ~~must have~~has clean bedding in good condition consisting of a mattress pad, bedspread, two (2) sheets, pillow, pillowcase, and blankets adequate for the weather.

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

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

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

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

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

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

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

(I) ~~Be~~Is in close enough proximity to the provider to alert the provider to nighttime needs or emergencies, or be equipped with an alert system.

(5) Food.

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

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

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

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

(6) Phone.

(A) ~~A~~ There is a working phone ~~must be provided~~ in the home that is available and accessible for the member's use, ~~for incoming and outgoing calls, including during periods of time when the member is home alone.~~

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

(7) Safety.

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

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

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

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

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

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

(8) Emergencies.

(A) Working smoke detectors ~~must be~~ provided in each bedroom, adjacent hallways, and in two (2) story homes, at the top of each stairway. Alarms ~~must be~~ equipped with a device that ~~warns of low battery condition,~~ has a low battery warning when battery operated.

(B) At least one (1) working fire extinguisher ~~must be~~ in a readily accessible location.

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

(D) The provider:

(i) ~~Mainstays~~ Maintains a working carbon monoxide detector in the home;

(ii) ~~Mainstays a~~ Maintains the home's written evacuation plan ~~for the home and conducts evacuation training for evacuation~~ with the member;

(iii) Conducts fire drills quarterly and severe weather drills twice per year;

(iv) Makes fire and severe weather drill documentation available for DDS review ~~by DDS~~;

(v) Has a written back-up plan for temporary housing in the event of an emergency; and

(vi) Is responsible ~~to re-establish~~ for re-establishing a residence; if the home

becomes uninhabitable.

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

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

(9) **Special hazards.**

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

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

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

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

(10) **Vehicles.**

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

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

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

(12) **Pets.** Sanitation for household pets and other domestic animals is required to prevent health hazards.

(A) For all household pets, proof of rabies and/or other vaccinations as required by a licensed veterinarian is maintained on the premises.

(B) Pets not confined in enclosures must not jeopardize the safety of residents and visitors to the home.

(C) Animals and pets are in good health, do not show evidence of carrying disease, and do not present a threat to member health, safety, or welfare.

(D) Appropriate supervision is required when the member is in the presence of household animals and pets.

(E) If an animal or pet bites a member, the provider ensures the member receives medical treatment when appropriate, contacts designated DDS staff as soon as the member is safe, and completes an incident report per OAC 340:100-3-34.

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

(1) Evaluating the applicant's:

(A) Interest and motivation;

(B) Life skills;

(C) Children;

(D) Methods of behavior support and discipline;

(E) Marital status, background, and household composition;

(F) Income and money management; and

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

(2) Assessment and recommendation. DDS staff:

(A) Evaluates the applicant's ability ~~of the applicant~~ to provide services;

(B) Assesses the applicant's overall compatibility of the applicant and with the service recipient, ensuring the lifestyles and personalities of each are compatible for the shared living arrangement. The applicant must:

- (i) ~~Express~~Expresses a long term commitment to the service member unless the applicant will only be providing respite services;
- (ii) ~~Demonstrate~~Demonstrates the skills to meet the ~~individual~~member's needs ~~of the member;~~
- (iii) ~~Express~~Expresses an understanding of the commitment required as a service provider of services;
- (iv) ~~Express~~Expresses an understanding of the impact the arrangement will have on personal and family life;
- (v) ~~Demonstrate~~Demonstrates the ability to establish and maintain positive relationships, especially during stressful situations; and
- (vi) ~~Demonstrates~~Demonstrates the ability to work collaboratively and cooperatively with others in a team process;

(C) ~~Approves only~~Only approves applicants who can fulfill ~~the~~service provider expectations of the role of service provider; and

(D) ~~When~~Ensures that when the applicant does not meet standards, per OAC 317:40-5-40, ~~ensures~~ the final recommendation includes:

- (i) A basis for the denial decision; ~~and~~
- (ii) An effective date for determining the applicant does not meet standards. ~~Reasons for denying a request to be a provider may include, but are not limited to;~~ and
- (iii) Reasons for denying a request to be a provider. Reasons may include, but are not limited to:

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

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

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

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

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

~~(VI) References who are guarded or have reservations in recommending the applicant;~~

~~(VII) The applicant failed to complete the application, required training, or verifications in a timely manner as requested or provided incomplete, inconsistent, or untruthful information;~~

(VI) The applicant's failure to complete verifications in a timely manner as requested, or the applicant's provision of incomplete, inconsistent, or untruthful information;

~~(VIII)~~(VII) The home is determined unsuitable for the member requiring

placement;

~~(IX)(VIII)~~ Confirmed abuse, neglect, or exploitation of any person;

~~(X) Breach of confidentiality;~~(IX) Confidentiality breach;

~~(XI) Involvement of the applicant~~(X) Applicant or provider involvement in criminal activity or criminal activity in the home;

~~(XII)(XI)~~ Failures to complete training, per OAC 340:100-3-38;

~~(XIII) Failures of the home~~(XII) Home's failure to meet standards per subsection (d) of this Section; ~~and~~

~~(XIV) Failures~~(XIII) Failure to follow applicable OKDHS or Oklahoma Health Care Authority (OHCA) rules;

(XIV) References who are guarded or have reservations in recommending the applicant; and

(XV) The applicant's failure to complete the application in a timely manner.

(E) Notifies the applicant in writing of the home profile's final approval or denial ~~of the home profile;~~ and

(F) ~~When an application is canceled or withdrawn prior to completion of the home profile, completes a final written assessment that includes the:~~Completes a final written assessment when an application is canceled or withdrawn prior to the home profile's completion. The written assessment includes the:

(i) Reason the application was canceled or withdrawn;

(ii) DDS ~~staff's~~staff impression of the applicant based on information obtained; and

(iii) Effective ~~date of cancellation or withdrawal;~~ date. Written notice is sent to the applicant to confirm application cancellation or withdrawal ~~of the application~~, and a copy is included in local and State Office records.

(f) Unrelated habilitation training specialist (HTS) staff home. Designated DDS staff and provider agency staff work together to complete a home evaluation when the member lives with an unrelated HTS staff.

(1) The provider agency:

(A) Obtains pre-employment screening in compliance with OAC 340:100-3-39;

(B) Obtains background checks for all household residents in accordance with (b) (4) of this Section; and

(C) Assesses HTS fitness for work; and the

(2) Designated DDS staff:

(A) Assesses household members' appropriateness;

(B) Develops an evacuation plan;

(C) Reviews policy, procedures, and responsibilities with the HTS;

(D) Ensures pet vaccinations are current;

(E) Evaluates any other conditions that may affect the health or safety of a member's care; and

(F) Completes a home safety inspection initially and annually, then as needed.

(f) Frequency of evaluation. **(g) Evaluation frequency.** Home profile evaluations are completed for an applicant's initial approval or denial ~~of an applicant.~~ After an initial approval, a home profile review is conducted annually and as needed for compliance and continued approval. DDS area residential services staff ~~conduct~~conducts at least biannual home visits to ~~specialized foster care~~SFC providers. The annual home profile review is a comprehensive review of the living arrangement, the provider's continued ability to meet standards, ~~the needs of the member and the~~

~~home~~ and the member's and home's needs to ensure ongoing compliance with home standards. A home profile review is conducted when a provider notifies DDS of his or her intent to move to a new residence. DDS staff assesses the home to ensure the new home meets home standards and is suitable to meet the member's needs. The annual home profile review;

- (1) Includes information specifically related to the provider's home and is documented, as an annual review;
- (2) Includes a medical examination report completed a minimum of every three (3) years following the initial approval, unless medical circumstances warrant more frequent completion;
- (3) Includes information from the DDS case manager, ~~the provider of agency companion or SFC services,~~ the Child Welfare specialist, Adult Protective Services, and Office of Client Advocacy staff, and the provider agency program coordinator when applicable;
- (4) Includes information from the service member indicating satisfaction with service and a desire to continue the arrangement;
- (5) Includes ~~areas of service~~ areas where improvement is needed;
- (6) Includes ~~areas of service~~ areas where progress was noted or were of significant benefit to the member;
- (7) Ensures background investigation, per OAC 317:40-5-40(b), is repeated every year, except for the OSBI and FBI national criminal history search;
- (8) Ensures the FBI national criminal history search, per OAC 317:40-5-40(b)(4)(A)(ii), is repeated every five (5) years;
- (9) ~~Ensures~~ When applicable, ensures written notification of continued provider approval to providers and agencies, ~~when applicable, of the continued approval of the provider;~~ and
- (10) Includes written notification to providers and agencies, when the provider or agency fails to comply with the home standards, per OAC 317:40-5-40, including correction deadlines for ~~correction~~ of the identified standards.

~~(g)~~ **(h) Home profile denial.** Reasons a home profile review may be denied include, but are not limited to, reasons stated in subsection (e) (2) (D) (iii) (I through XIII) of this Section and :

- (1) ~~Lack of stable, adequate income to meet the provider's own or total family needs or poor management of available income;~~
- (2) ~~A physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;~~
- (3) ~~The age, health, or any other condition of the provider that impedes the provider's ability to provide appropriate care for a member;~~
- (4) ~~Relationships in the provider's household that are unstable and unsatisfactory;~~
- (5) ~~The mental health of the provider or other family or household member impedes the provider's ability to provide appropriate care for a member;~~
- (6) ~~The provider fails to complete required training, or verifications in a timely manner as requested or provides incomplete, inconsistent, or untruthful information;~~
- (7) ~~The home is determined unsuitable for the member;~~
- (8) ~~Failure of the provider~~ (1) Provider's failure to complete tasks related to problem resolution, as agreed, per OAC 340:100-3-27;
- (9) ~~Failure of the provider~~ (2) Provider's failure to complete a ~~plan of action,~~ an action plan, as agreed, per OAC 317:40-5-63;
- (10) Confirmed abuse, neglect, or exploitation of any person;
- (11) Breach of confidentiality;

- ~~(12) Involvement of the applicant or provider involvement in the criminal activity or criminal activity in the home;~~
 - ~~(13)(3) Failure to provide for the service member's care and well-being of the service member;~~
 - ~~(14)(4) Failure or continued failure to implement the individual member's Individual Plan, per OAC 340:100-5-50 through 100-5-58;~~
 - ~~(15) Failure to complete and maintain training, per OAC 340:100-3-38;~~
 - ~~(16)(5) Failure to report changes in the household;~~
 - ~~(17) Failure to meet standards of the home per subsection (d) of this Section;~~
 - ~~(18) Failure or continued failure to follow applicable OKDHS or OHCA rules;~~
 - ~~(19)(6) Decline of in the provider's health to the point he or she can no longer meet the service member's needs of the service member;~~
 - ~~(20) Employment by the provider~~(7) Provider employment without prior approval of the DDS area programs manager for residential services; DDS area residential services programs manager approval; or
 - ~~(21)(8) Domestic disputes that cause emotional distress to the member.~~
- (h) ~~Termination of placement.~~ (i) Placement termination. When an existing placement is terminated for any reason:
- (1) The Team meets to develop an orderly transition plan; and
 - (2) DDS staff ensures the member's and state property ~~of the member and state is~~ are removed promptly and appropriately by the member or his or her designee.

SUBCHAPTER 5. SPECIALIZED FOSTER CARE

317:40-5-50. Purpose of Specialized Foster Care Scope

- (a) Specialized Foster Care (SFC) provides up to ~~24~~twenty-four (24) hours per day of in-home residential habilitation services funded through the Community Waiver or the Homeward Bound Waiver. SFC serves individuals ~~ages three (3) years of age~~ and older. SFC provides an individualized living arrangement in a family setting including up to ~~24~~twenty-four (24) hours per day of supervision, supportive assistance, and training in daily living skills.
- (b) SFC is provided in a setting that best meets the member's specialized needs ~~of the service recipient~~.
- (c) Members in SFC have a written plan that addresses visitation, reunification, or permanency planning, and which may also address guardianship as the member approaches eighteen (18) years of age.
- (d) As per the requirements in (1) through (4) of this subsection, SFC providers:
 - (1) Are approved through the home profile process described in Oklahoma Administrative Code (OAC) 317:40-5-40;
 - (2) Have a current Home and Community-Based Services (HCBS) Waiver contract with the Oklahoma Health Care Authority; and
 - (3) Have a current Fixed Rate Foster Home Contract for room and board reimbursement with Developmental Disabilities Services (DDS) when:
 - (A) The member is a child; or
 - (B) Required by the adult member's Personal Support Team (Team).

(e) A child in Oklahoma Human Services (OKDHS) or tribal custody who is determined eligible for HCBS Waiver services, per OAC 317:40-1-1, is eligible to receive SFC services if the child's special needs cannot be met in a Child Welfare Services (CWS) foster home.

(1) SFC provides a temporary, stable, nurturing, and safe home environment for the child while OKDHS plans for reunification with the child's family.

(2) In the event reunification is not achievable, SFC may be provided on a long-term basis while other more permanent living arrangements are sought.

(3) When the court has established a specific visitation plan, the CWS specialist informs the SFC provider, the member, the DDS case manager, and the natural family of the visitation plan.

(A) The SFC provider cooperates with the visitation plan between the child and family as prescribed by the court or the member's Team.

(B) The reunification effort is the joint responsibility of the:

(i) CWS worker;

(ii) DDS case manager;

(iii) Natural family; and

(iv) SFC family.

(C) For children in OKDHS custody, CWS and DDS work together to determine the need for guardianship. When it has been established that a legal guardian is in the child's best interest, both programs work together to locate a guardian.

(f) SFC is a temporary service provided to children who are not in OKDHS custody when SFC services are needed to prevent institutionalization.

(1) SFC intent is to allow the member's family relief that cannot be satisfied by respite services provisions or other in-home supports.

(2) SFC provides a nurturing, substitute home environment for the member while plans are made to reunify the family.

(3) Visitation with the family is a part of the reunification efforts for non-custody children. Visitation must not be intrusive to the SFC home.

(4) Parents of a child receiving SFC services must comply with the requirements listed in (A) through (D) of this paragraph.

(A) Natural or adoptive parents retain the responsibility for their child's ongoing involvement and support while the child is in SFC.

(i) The parents are required to sign a written agreement allowing OKDHS to serve as the representative payee for the child's Social Security Administration (SSA) benefits, other government benefits, and court-authorized child support.

(ii) SSA and other government benefits, and child support are used to pay for room and board (maintenance). HCBS services do not pay for room and board (maintenance).

(B) Parental responsibilities of a child receiving voluntary SFC are to:

(i) Provide respite to the SFC provider;

(ii) Provide transportation to and from parental visitation;

(iii) Provide a financial contribution toward their child's support;

(iv) Provide in kind supports, such as disposable undergarments, if needed, clothing, recreation, birthday and holiday presents, school supplies, and allowances or personal spending money;

(v) Follow the visitation plan as outlined by the member's Team, per OAC 317:40-5-52;

(vi) Maintain ongoing communication with the member and SFC provider by letters, telephone calls, video conferencing, or email;

(vii) Be available in an emergency;

(viii) Work toward reunification when appropriate;

(ix) Provide written consent for medical treatments as appropriate;

(x) Attend medical appointments, when possible, and keep informed of the member's health status;

(xi) Participate in the member's education plan in accordance with Oklahoma State Department of Education regulations; and

(xii) Be present for all Team meetings.

(C) When moving out of Oklahoma, parents of a child receiving voluntary SFC are responsible for taking their minor child with them, since the child is no longer eligible for services because he or she is no longer an Oklahoma resident.

(D) For children eighteen (18) years of age and younger, the case manager reports to CWS if the family moves out of Oklahoma without taking their child with them or if the family cannot be located.

(g) SFC is an appropriate living arrangement for many adults. The decision to use SFC for an adult is based on the member's need for residential support as described in his or her Individual Plan.

(1) In general, SFC is appropriate for members who have not experienced family life. A child served in SFC may continue to receive services in the home indefinitely after turning eighteen (18) years of age.

(2) The member who receives SFC services lives in the provider's home.

(3) Visitation with the adult member's family is encouraged and arranged according to the member's preference. Visitation is not intrusive to the SFC home.

317:40-5-51. Scope of Specialized Foster Care [REVOKED]

~~(a) **Children in OKDHS custody.** A child in the custody of the Oklahoma Department of Human Services (OKDHS) who is determined eligible for HCBS Waiver services in accordance with OAC 317:40-1-1 is eligible to receive Specialized Foster Care (SFC) services if the special needs of the child cannot be met in a Division of Children and Family Services (DCFS) foster home.~~

~~(1) SFC provides a temporary, stable, nurturing, and safe home environment for the child while the OKDHS plans for reunification with the child's family.~~

~~(2) In the event reunification is not achievable, SFC may be provided on a long-term basis while other more permanent living arrangements are sought.~~

~~(b) **Non-custody children.** SFC is a temporary service provided to children who are not in the custody of OKDHS when needed to prevent institutionalization.~~

~~(1) The intent of SFC is to allow the service recipient's family relief that cannot be satisfied by the provision of respite services or other in-home supports.~~

~~(2) SFC provides a nurturing, substitute home environment for the service recipient while plans are made to reunify the family.~~

~~(3) Parents of a child receiving SFC services must comply with requirements of OAC 317:40-5-56.~~

~~(c) **Adults.** SFC is an appropriate living arrangement for many adults. The decision to use SFC for an adult is based on the service recipient's need for residential support as described in his or her Plan.~~

~~(1) In general, SFC is appropriate for service recipients who have not experienced family life. A child served in SFC may continue to receive services in the home indefinitely after turning 18 years of age.~~

~~(2) The service recipient who receives SFC services lives in the provider's home.~~

317:40-5-52. Visitation and reunification in Specialized Foster Care [REVOKED]

~~Service recipients in Specialized Foster Care (SFC) have a written plan that addresses visitation, reunification, or permanency planning, and which may also address guardianship as the service recipient approaches age 18.~~

~~(1) **Custody children.** When the Court has established a specific visitation plan, the Division of Children and Family Services (DCFS) specialist informs the SFC provider, the service recipient, the Developmental Disabilities Services Division (DDSD) case manager, and the natural family of the visitation plan.~~

~~(A) The SFC provider cooperates with the visitation plan between the child and family as prescribed by the Court or the service recipient's Team.~~

~~(B) The reunification effort is a joint responsibility of:~~

~~(i) the DCFS worker;~~

~~(ii) the DDSD case manager;~~

~~(iii) the natural family; and~~

~~(iv) the SFC family.~~

~~(C) For children in the custody of the Oklahoma Department of Human Services (OKDHS) who are attaining the age of 18, DCFS and DDSD work together to determine the need for guardianship. When it has been established that a legal guardian is in the child's best interest, both divisions work together to locate a guardian.~~

~~(2) **Non-custody children.** Visitation with the family is a part of the reunification efforts for non-custody children. Visitation must not be intrusive to the SFC home.~~

~~(3) **Adults.** Visitation with the adult service recipient's family is encouraged and arranged according to the preference of the service recipient. Visitation must not be intrusive to the SFC home.~~

317:40-5-54. Selection of Specialized Foster Care provider [REVOKED]

~~Providers of Specialized Foster Care (SFC) must meet the requirements of this Section.~~

~~(1) Each provider is approved through the home profile process described in OAC 317:40-5-40.~~

~~(2) The individual provider of Specialized Foster Care is required to have a current Home and Community Based Waiver (HCBW) services contract with the Oklahoma Health Care Authority.~~

~~(3) The provider is required to have a current Fixed Rate Contract for room and board reimbursement with Developmental Disabilities Services Division (DDSD) when:~~

~~(A) the SFC service recipient is a child; or~~

~~(B) required by the adult SFC recipient's Team.~~

~~(4) OKDHS Form DCW-SH 2, Claim for Foster and Adoptive Home Purchase of Care, if required in accordance with paragraph (3) of this subsection, is completed and submitted~~

monthly to OKDHS Finance by staff as designated by the DDSD area manager.

317:40-5-55. Specialized Foster Care (SFC) provider responsibilities

(a) **General responsibilities.** ~~The responsibilities of all Specialized Foster Care (SFC) providers~~The SFC providers responsibilities are listed in (a) through (c) of this Section. Each provider:

(1) ~~Providers of SFC are required~~Is required to meet all applicable standards per OAC 317:40-5-40.;

(2) ~~Providers of SFC are required~~Is required to receive ~~competency-based~~competency-based training per OAC 340:100-3-38. The provider keeps all required training ~~up to date~~current and submits documentation to the SFC specialist at the time training is completed.;

(3) ~~The provider is an~~Is an active participant of the member's Personal Support Team (Team) and assists in ~~the development of~~developing the member's Individual Plan (Plan), per OAC 340:100-5-50 through 100-5-58.;

(4) ~~The provider documents~~Documents and notifies the case manager of any changes in ~~behavior~~the member's behavior or medical conditions ~~of the member~~ within one working day. ~~Incident reports are completed by the SFC provider and submitted~~The SFC provider completes incident reports and submits them to the Developmental Disabilities Services ~~Division (DDSD)~~(DDS) case manager per OAC 340:100-3-34.;

(5) ~~The SFC provider is~~Is available to the member at any time.;

(6) ~~The~~Has primary responsibility ~~of the SFC provider is~~ to provide SFC services to the member. The SFC provider does not have employment unless the employment ~~has been~~is pre-approved by the ~~residential programs supervisor for DDSD~~DDS area residential services programs manager or the State Office residential services programs manager;

(A) ~~Generally, providers are not approved for employment because the~~The provider must be available before and after school or vocational programs and ~~often~~as needed during the day due to holidays or illnesses.;

(B) ~~If, after~~After receiving employment approval for employment, it is found that ~~if the SFC provider's employment interferes with the member's care, training, or supervision needed by the member,~~ the provider must determine if he or she wants to terminate the employment or have the member moved from the home.;

(C) ~~DDSD~~DDS does not authorize ~~Homemaker, Habilitation Training Specialist,~~homemaker, habilitation training specialist, or respite services in order for the SFC provider to perform employment.

(7) ~~The provider does~~Does not deliver services that duplicate ~~the~~public school district mandated services ~~mandated to be~~that are provided by the public school district pursuant to the Individuals ~~With~~with Disabilities Education Act (IDEA-B).;

(8) ~~The provider allows~~Allows the member to have experiences, both in and out of the home, to enhance the member's development, learning, growth, independence, community inclusion, and well-being, while assisting the member to achieve his or her maximum level of independence.;

(9) ~~The provider ensures~~Ensures confidentiality is maintained regarding the member per OAC 340:100-3-2.;

(10) ~~The provider is~~Is sensitive to, and assists the member in participating in, the member's ~~choice of~~religious faith. No member is expected to attend any religious service against his or her wishes.;

(11) ~~The provider arranges,~~Arranges for, and ensures ~~that~~ the member obtains, a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed.;

(12) ~~The provider has~~Has a valid Oklahoma driver license, and maintains a motor vehicle in working order, ~~and complies with requirements of per~~OAC 317:40-5-103, Transportation.;

(13) ~~The provider transports~~Transports, or arranges transportation, ~~using adapted transportation when appropriate,~~ for the member, ~~to and from school, employment, church, recreational activities, and medical or therapy appointments.~~using adapted transportation when appropriate, per OAC 317:40-5-103, the SFC provider.;

(A) ~~SFC providers may~~May enter into a transportation contract.;

(B) ~~The provider must assure~~Assures availability and use of an approved and appropriate child auto restraint system as required by law in transporting children and, in cases of adults receiving services, any additional safety devices identified as necessary in the Plan.;

(C) Does not claim transportation reimbursement for vacation travel or any other transportation service not covered per OAC 317:40-5-103.

(14) ~~The provider assures~~Assures the member is clean, appropriately dressed, and on time for activities and appointments.;

(15) ~~The provider ensures~~Ensures no other adult or child is cared for or resides in the home on a regular or part-time basis ~~that was~~who is not approved through the home profile review process or without prior approval from the ~~DDS~~DDS area residential services programs manager or designee.;

(16) ~~The provider does~~Does not provide services to more than three (3) individuals regardless of ~~the type of service provided,~~service type provided, including SFC, ~~Children and Family Services Division~~Welfare Services foster care, respite, baby-sitting, or other such services. Any exception to this paragraph must be approved in writing by the ~~director of DDS~~director or designee prior to authorization or service delivery.;

(17) ~~The provider permits visitation and monitoring of the home by authorized DDS staff.~~Permits DDS staff to conduct monitoring and home visits. In order to assure ~~maintenance of standards,~~are maintained, some visits are unannounced. The visits occur at least monthly and are not intended to be intrusive but to ensure the member's safety and well-being ~~of the member.~~;

(18) ~~The provider encourages~~Encourages and cooperates in planning visits in the SFC home by the member's relatives, guardians, or friends ~~of the member.~~ Member visits to his or her friends' or relative's homes must be approved by the member's legally authorized representative.;

(19) ~~The provider abides by the policies of DDS per OAC 340:100-3-12, Prohibition of client abuse, and OAC 340:100-5-58, Prohibited procedures.~~ ~~The provider is~~Is prohibited from signing an authorization for school personnel to use physical discipline or corporal punishment.;

(20) ~~The provider notifies~~Notifies the ~~DDS case manager~~DDS social services specialist (SSS) when the need arises for substitute supervision in ~~the event of an emergency, in accordance with the Backup Plan,~~ per OAC 317:40-5-59. ~~If~~When the provider is out of the home for a short duration, a natural support in the home can provide time-limited substitute supervision.;

(A) A natural support is defined as an adult relative or spouse of the specialized foster

parent ~~that~~who resides in the home-;

(B) The Team approves the natural support and defines when this support may be accessed-;

(C) Persons ~~who are~~ considered a natural support must complete training, per OAC 340:100-3-38.12-;

(D) Persons acting as a natural support may only provide supervision for brief, intermittent time periods- and do so without payment;

(E) When the Team determines it to be appropriate, the SFC provider may select a volunteer to serve as a substitute caregiver for a member eighteen (18) years of age and younger. The volunteer resides outside the home, has no waiver contract, is not employed by a contracted agency, and has an established relationship with the member;

(i) A volunteer is defined as an adult, at least twenty-one (21) years of age, who is the SFC provider's a friend, relative, or neighbor;

(ii) A volunteer may provide support for up to two (2) consecutive days. The member may not be in volunteer care for more than three (3) days total in a thirty (30) calendar day period;

(iii) The SFC provider ensures the volunteer possesses the maturity and skills necessary to address the member's needs;

(iv) The foster care provider notifies the DDS SSS within one (1) business day when volunteer respite is used and includes address, contact information and length of stay;

(v) When the member is also a child in OKDHS or tribal custody, the SFC provider gives the volunteer contact information for the DDS SSS, case manager, and child welfare specialist (CWS) as well as his or her own contact information;

(vi) A volunteer must not be someone who has been excluded by OKDHS; and

(vii) The volunteer is not subject to background check or home profile requirements unless the stay will exceed two (2) consecutive days.

(F) When the Team determines it to be appropriate, the SFC provider may select a camp, retreat, or conference program as a substitute caregiver for the member when the member wishes to attend the program. A camp, retreat, or conference program is defined as a day or overnight program with adult supervision for children, teenagers, or adults conducted for educational, athletic, or cultural development. The SFC provider:

(i) Ensures the program has the essential skills and supports to meet the member's needs;

(ii) Notifies the DDS SSS prior to the member attending the program; and

(iii) Provides the program with contact information for the foster care provider, DDS SSS, case manager, and CWS when the member is also a child in OKDHS or tribal custody.

~~(21) The provider provides written 30-day~~Provides written thirty (30) calendar day notice to the member and ~~DDS~~DDS case manager when it is necessary for a member to be moved from the home-;

~~(22) The SFC provider does~~Does not serve as the member's representative payee for the member-;

~~(23) The provider ensures~~Ensures the member's funds are properly safeguarded-;

~~(24) The provider assists~~Assists the member in accessing and using entitlement programs for which the member may be eligible-;

(25) ~~The provider must~~ Must use the room and board reimbursement payment to meet the member's needs, as specified in ~~per the room and board contract.~~ Fixed Rate Foster Home Contract;

(A) The provider retains a copy of the current ~~room and board contract~~ Fixed Rate Foster Home Contract in the home at all times-;

(B) Items purchased with the room and board reimbursement include, but are not limited to:

(i) ~~housing~~; Housing;

(ii) ~~food~~; Food;

(iii) ~~clothing~~; Clothing;

(iv) ~~care~~; Care;

(v) ~~incidental~~ Incidental expenses such as:

(I) ~~birthday~~ Birthday and Christmas gifts;

(II) ~~haircuts~~; Haircuts;

(III) ~~personal~~ Personal grooming equipment;

(IV) ~~allowances~~; Allowances;

(V) ~~toys~~; Toys;

(VI) ~~school~~ School supplies and lunches;

(VII) ~~school~~ School pictures;

(VIII) ~~costs~~ Costs of recreational activities;

(IX) ~~special~~ Special clothing items required for dress occasions and school classes such as gym shorts and shirts;

(X) ~~extracurricular~~ Extracurricular athletic and other equipment, including uniforms, needed for the member to pursue his or her particular interests or job;

(XI) ~~prom~~ Prom and graduation expenses including caps, gowns, rings, pictures, and announcements;

(XII) ~~routine~~ Routine transportation expenses involved in meeting the member's medical, educational, or recreational needs, unless the provider has a transportation contract;

(XIII) ~~non-prescription~~ Non-prescription medication; and

(XIV) ~~other~~ Other maintenance supplies required by the member.

(C) All items purchased for the member with the room and board payment are the ~~member's property of the member.~~ Purchased items are documented on OKDHS Form 06AC022E, Personal Possession Inventory, and are given by the provider provided to the member when a residence change of residence occurs-; and

(D) The room and board payment is made on a monthly basis and is prorated based on the actual days the member is in the home on the initial and final months of residence.

(26) ~~The provider maintains a~~ Maintains Form 06AC022, Personal Possession Inventory, Form 06AC022E (DDS-22) for each member living in the home-;

(27) ~~The provider maintains~~ Maintains the member's home record, per OAC 340:100-3-40-;

(28) ~~The provider immediately~~ Immediately reports to the ~~DDSD SFC staff~~ DDS SSS all changes in the household including, but not limited to:

(A) ~~telephone~~ Phone number;

(B) ~~address~~; Address;

(C) ~~marriage~~ Marriage or divorce;

- (D) ~~persons~~Persons moving into or out of the home;
- (E) ~~provider's~~Provider's health status;
- (F) ~~provider's~~Provider's employment; and
- (G) ~~provider's~~Provider's income.

(29) ~~The provider maintains~~Maintains home owner's or renter's insurance, including applicable liability coverages, and provides a copy to the ~~SFC Specialist~~DDS SSS;

(30) ~~The provider serves~~Serves as the ~~Health Care Coordinator~~health care coordinator, and follows the ~~Health Care Coordinator policy~~rules per OAC 340:100-5-26; and

(31) ~~Each SFC provider follows~~Follows all applicable OKDHS and Oklahoma Health Care Authority rules, of the Oklahoma Department of Human Services and the Oklahoma Health Care Authority, promotes the independence of the member, and follows recommendations of the member's ~~Team~~included but not limited to:

(A) OAC 340:100-3-27;

(B) OAC 340:100-5-32; and

(C) OAC 340:100-5-33.

(b) **Responsibilities specific to SFC providers serving children.** The provider is charged with the same general legal responsibility as any parent ~~has to exercise~~. The SFC provider exercises reasonable and prudent behavior in his or her actions and in the supervision and support of the child. The SFC provider:

(1) ~~The provider works~~Works with the ~~DDS~~DDS case manager and ~~CFSD~~CWS staff when the provider needs respite for a child in OKDHS or tribal custody;

(2) ~~The provider participates~~Participates in the ~~development of~~developing the Individual Education Plan (IEP) and may serve as surrogate parent when appropriate;

(3) ~~The provider obtains~~Obtains permission and legal consent from the child's custodial parent or guardian and ~~DDS~~DDS case manager prior to traveling ~~out of state~~out-of-state for an overnight visit. If the child is in the OKDHS or tribal custody, ~~of the OKDHS, the CWS permission of the CFSD specialist is also secured~~;

(4) ~~The provider obtains~~Obtains permission and legal consent from the child's custodial parent or guardian and ~~DDS~~DDS case manager prior to the child's involvement of the child in any publicity. If the child is in OKDHS or tribal custody, ~~the CWS permission of the CFSD specialist is also secured~~; and

(5) The provider reports any suspected abuse, neglect, sexual abuse, or sexual exploitation of children ~~per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Abuse Hotline at 1-800-522-3511~~to CWS, per 10A O.S. § 1-2-101 and OAC 340:2-3-33.

(c) **Responsibilities specific to SFC providers serving adults.** Additional SFC provider responsibilities for serving adults are given in this Subsection.

(1) The SFC provider obtains permission from the member's legal guardian, when applicable, and notifies the ~~DDS~~DDS case manager, prior to:

(A) ~~traveling out of state~~Traveling out-of-state for an overnight visit; or

(B) ~~The member's involvement of the member~~ in any publicity.

(2) When the member is his or her own payee or has a representative payee, the SFC provider ensures the monthly service contribution, ~~for services~~ as identified in a written agreement between the member and the SFC provider, is used toward the cost of food, rent, and household expenses.

(A) The member's minimum monthly contribution is ~~\$250.00~~\$300.00 per month.

(B) Changes in the member's monthly contribution are ~~developed~~made on an

individualized basis by the member's Team.

(3) ~~Reports~~The SFC provider reports any suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, and/or or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes to the Office of Client Advocacy (OCA):to:

(A) The Office of Client Advocacy for a vulnerable adult receiving Home and Community-Based Services (HCBS) when the alleged perpetrator is a community service worker, per OAC 340:2-3-33; or

(B) Adult Protective Services for a vulnerable adult when the alleged perpetrator is not a community service worker through HCBS, per 43A O.S. § 10-104.

317:40-5-56. Responsibilities of the parents of individuals in voluntary specialized foster care [REVOKED]

~~(a) Natural or adoptive parents retain the responsibility for on-going involvement and support of their child while the child is in specialized foster care (SFC).~~

~~(1) The parents are required to sign a written agreement allowing the Oklahoma Department of Human Services (OKDHS) to serve as the representative payee for the child's Social Security, other government benefits, and court authorized child support.~~

~~(2) Social Security, other government benefits, and child support are used to pay for room and board (maintenance). Home and Community Based Services (HCBS) services do not pay for room and board (maintenance).~~

~~(b) Responsibilities of the parents of a child receiving voluntary SFC are:~~

~~(1) to provide respite to the foster SFC provider;~~

~~(2) to provide transportation to and from parental visitation;~~

~~(3) to provide a financial contribution toward the support of their child;~~

~~(4) to provide in-kind supports such as disposable undergarments if needed, clothing, recreation, birthday and holiday presents, school supplies, and allowances or personal spending money;~~

~~(5) to follow the visitation plan as outlined by the service recipient's Team; (see OAC 317:40-5-52);~~

~~(6) to maintain ongoing communication with the service recipient and SFC provider by letters and telephone calls;~~

~~(7) to be available in the event of an emergency;~~

~~(8) to work toward reunification when appropriate;~~

~~(9) to provide written consent for medical treatments as appropriate;~~

~~(10) to attend medical appointments, when possible, and keep informed of the service recipient's health status;~~

~~(11) to participate in the service recipient's education plan in accordance with the Department of Education regulations; and~~

~~(12) to be present for all Team meetings.~~

~~(c) When moving out of Oklahoma, parents of a child receiving voluntary SFC are responsible to take their minor child with them, since the child is no longer eligible for services because he or she is no longer a resident of the State of Oklahoma.~~

~~(d) For children under age 18, the case manager reports to DCFS if the family moves out of Oklahoma without taking their child with them or cannot be located.~~

317:40-5-57. Developmental Disabilities Services Division ~~DDS~~ Specialized Foster Care (SFC) case ~~manager~~ management roles and responsibilities ~~regarding Specialized Foster Care~~

In addition to other identified roles and responsibilities, the ~~Developmental Disabilities Services Division (DDSD)~~ DDS case manager is responsible for:

- (1) ~~reporting~~ Reporting any significant changes with the member or the SFC household to the ~~SFC specialist;~~ DDS social service specialist (SSS);
- (2) ~~assessing~~ The member's guardianship needs;
- (3) ~~facilitating pre-placement~~ Pre-placement visits when approved by the ~~SFC specialist;~~ DDS SSS;
- (4) ~~monitoring for current~~ Reviewing the member's backup plan, as described in OAC per Oklahoma Administrative Code (OAC) 317:40-5-59;
- (5) ~~monitoring the service recipient's personal inventory, Form DDS-22;~~ Reporting policy violations to the DDS SSS per OAC 317:40-5-63, and assists the DDS SSS in developing the provider's action plan when appropriate;
- (6) ~~monitoring the service recipient's funds and resources monthly;~~ Ensuring the SFC provider documents the member's personal belongings on Oklahoma Human Services (OKDHS) Form 06AC022, Personal Possession Inventory, including adaptive equipment;
- (7) ~~reporting any potential violations of policy and standards to the SFC specialist in accordance with OAC 317:40-5-63 and assisting with the development of the provider's plan of action, if appropriate;~~ Attending court hearings for children in OKDHS and tribal custody;
- (8) ~~assisting in the inventory of any necessary adaptive equipment, Form DDS-22;~~ Forwarding quarterly progress reports to the OKDHS Child Welfare Services (CWS) specialist for children in OKDHS custody;
- (9) ~~attending Court hearings for custody children;~~ Notifying the CWS or legally authorized representative of needed medical consents for pre-planned or emergency services; and
- (10) ~~forwarding copies of monthly contact reports on custody children to the DCFS specialist;~~ Completing the appropriate section of OKDHS Form 06AC024E, SFC/Agency Companion Services (ACS) Annual Review, and providing the information to the DDS SSS.
- (11) ~~notifying the DCFS specialist or legally authorized representative of needed medical consents for pre-planned or emergency services; and~~
- (12) ~~completing appropriate section of Form DDS-24, Annual Review, and providing the information to the SFC specialist.~~

317:40-5-58. Developmental Disabilities Services Division ~~(DDS)~~ Specialized Foster Care (SFC) ~~staff~~ Social Services Specialist (SSS) roles and responsibilities

~~Developmental Disabilities Services Division (DDSD) SFC~~ DDS SSS staff have the responsibility for:

- (1) SFC applicant orientation and prescreening of ~~SFC applicants;~~
- (2) ~~making~~ Making contact with the potential SFC provider within five (5) working days of ~~receipt of~~ receiving a completed application to schedule interviews and start the ~~Home Profile Process, described in~~ home profile process, per OAC 317:40-5-40;
- (3) ~~completing the Home Profile~~ Completing the home profile within ~~90 working~~ ninety (90) calendar days after application assignment of the application. The ~~SFC specialist~~ DDS SSS documents the reason for any delay beyond ~~90~~ ninety (90) calendar days;
- (4) ~~maintaining~~ Maintaining regular contact with the SFC provider by making a monitoring

visit every six (6) months with a minimum of one telephone contact in all other months and completing OKDHS Form 06AC023E, Monitoring Report;

(A) ~~The SFC specialist completes the Monitoring Report (DDS 23) for each monitoring review.~~

(B) ~~Items to be discussed during the telephone contacts are detailed in the Monthly Contact Monitoring Guide.~~

(5) ~~completing a~~ Completing OKDHS Form 06AC024E, Specialized Foster Care/Agency Companion Annual Review (DDS-24) for the annual re-evaluation of each SFC provider home by the renewal date;

(6) ~~attending~~ Attending member's Personal Support Team meetings for service recipients in SFC as necessary;

(7) ~~responding to requests for~~ Responding to SFC and respite care; requests;

(8) ~~providing~~ Providing technical assistance and training to SFC providers regarding claims and resolution of problems; problem resolutions, such as:

(A) ~~payments;~~ Payments;

(B) ~~family~~ Family dynamics;

(C) ~~DDS~~ DDS policy;

(D) ~~setting~~ Setting up the in-home record as described in per OAC 340:100-3-40;

(E) ~~setting~~ Setting up the SFC provider record; and

(F) SFC provider training;

(9) ~~making~~ Making unannounced home visits to ensure homes and providers are in compliance with DDS standards and DDS policy;

(10) ~~reporting to DDS State Office Training Staff as the provider's training occurs and is updated:~~

(A) ~~the provider's name;~~

(B) ~~the provider's Social Security Number; and~~

(C) ~~dates and places of specific provider training;~~ Providing SFC providers with technical assistance and training regarding room and board responsibilities.

(11) ~~facilitating a written agreement for room and board contributions on behalf of the service recipient, if the Oklahoma Department of Human Services is not the representative payee for the service recipient;~~ Completing or obtaining the authorization for SFC services on OKDHS Form 06AC075E, Authorization Form Parent or Guardian for Specialized Foster Care Placement and Medical Care of Client, that:

(A) Is signed by the parent or legal guardian for members not in OKDHS or tribal custody who are requesting SFC services; and

(B) Allows for authorization of routine or emergency medical care and provides insurance information.

(12) ~~completing or obtaining the:~~

(A) ~~Room and Board Reimbursement for Foster Care (DCW FH 2);~~

(B) ~~Authorization for SFC Services (DDS SFC 1), that:~~

(i) ~~is signed by the parent or legal guardian for service recipients not in custody who are requesting SFC services; and~~

(ii) ~~allows for authorization of routine or emergency medical care and provides insurance information.~~

317:40-5-59. Back-up Plan for persons members receiving Specialized Foster Care (SFC)

Prior to a member moving into ~~Specialized Foster Care (SFC)~~, SFC, the SFC provider and the ~~SFC specialist~~ Developmental Disabilities Services (DDS) social services specialist (SSS) develop a Back-up Plan. The ~~SFC specialist~~ DDS SSS communicates the Back-Up Plan in writing to the ~~DDS~~ DDS case manager for incorporation into the Individual Plan.

- (1) The Back-up Plan identifies the person(s) who provides emergency back-up supports.
- (2) The member's natural family is considered as the first resource for the Back-up Plan at no cost to ~~OKDHS~~, Oklahoma Human Services (OKDHS), unless the member is in ~~the OKDHS or tribal custody of the Oklahoma Department of Human Services.~~
- (3) The Back-up Plan contains the name(s) and current ~~telephone~~ phone number(s) of the person(s) providing back-up service.

(4) When paid SFC providers are necessary, the Back-up Plan explains specifically where the service is to be provided.

(A) If back-up service is to be provided outside the SFC home, ~~a Home Profile must be completed for the back-up staff per OAC 317:40-5-40.;~~

(i) By a volunteer or at a camp, retreat, or conference center, the Personal Support Team's process must be followed as described in OAC 317:40-5-56; or

(ii) In a contracted SFC provider's home, a home profile must be completed for the back-up staff per OAC 317:40-5-40.

(B) If back-up service is to be provided in the SFC home, the person providing this service must have completed all necessary requirements to become a paid SFC provider, including:

(i) ~~an~~ An Oklahoma State Bureau of Investigation (OSBI) name and criminal ~~history~~ records ~~history~~ search, including the Department of Public Safety (~~DPS~~), Sex Offender, and Mary Rippy Violent Offender ~~Registries;~~ registries;

(ii) ~~a~~ A Federal Bureau of Investigation (~~FBI~~) national criminal history search, based on the applicant's fingerprints ~~of the applicant;~~

(iii) ~~a~~ A search of any involvement as a party in a court ~~action that~~ action that may impact the member's safety or stability ~~of the member~~ that includes:

(I) ~~victims~~ Victims protective order; or

(II) ~~bankruptcy;~~ Bankruptcy;

(iv) ~~a~~ A search of all ~~Oklahoma Department of Human Services (OKDHS)~~ OKDHS records, including ~~child welfare (CW)~~ Child Welfare Services' records;

(v) ~~a~~ A search of all applicable out-of-state child abuse and neglect registries for any applicant who has not lived continuously in Oklahoma for the past five years. The applicant is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, if a registry is maintained in the applicable state;

(vi) Community Services Worker registry check;

(vii) Oklahoma statutorily mandated liability insurance coverage, and a valid driver license; and

(viii) ~~completion~~ Completion of required ~~DDS~~ DDS training per OAC 340:100-3-38.4.

(C) The Back-up Plan details where the member and SFC provider will stay if the SFC provider's home is not habitable. If there is a fee to stay in the alternate location, the provider pays the fee ~~is paid by the provider~~ and is not reimbursed by ~~DDS~~ DDS.

(5) The Back-up Plan is jointly reviewed at least monthly by the ~~SFC specialist~~ DDS SSS and the SFC provider to ensure the Back-up Plan continues to be appropriate and current.

(6) The SFC provider is responsible to report for reporting any needed changes in the Back-up Plan to the ~~SFC specialist~~. DDS SSS.

(7) The ~~SFC specialist will report~~ DDS SSS reports any changes in the Back-up Plan to the DDS case manager.

317:40-5-62. ~~Evaluation of Specialized Foster Care (SFC) policy violation~~ violations or program concern in a specialized foster care home concerns

(a) ~~Developmental Disabilities Services Division (DDSD)~~ DDS Specialized Foster Care (SFC) staff begin an evaluation process upon receipt of a complaint or observation of ~~program concern(s) or policy violation(s) by the provider.~~ SFC provider policy violations or concerns.

(b) Concerns may include: the SFC provider's:

(1) ~~provider's use~~ Use of judgment;

(2) ~~provision~~ Provision of program supervision;

(3) ~~non-compliance~~ Non-compliance with ~~DDSD~~ Oklahoma Human Services or Oklahoma Health Care Authority policy or contract; or

(4) ~~other~~ Other related issues.

(c) When abuse, neglect, or exploitation is suspected, appropriate authorities are contacted, as specified in OAC 317:40-5-61.

(d) The evaluation includes interviews with:

(1) ~~the~~ The service recipient;

(2) ~~the~~ The DDSD case manager;

(3) ~~the~~ The provider;

(4) ~~any~~ Any other person(s) living in the home; and

(5) ~~any~~ Any other person(s) who may have relevant information.

(e) When the evaluation findings indicate ~~programming concern(s) or violation(s) of policy or contract, the DDSD SFC staff,~~ policy or contract concerns or violations, the DDS social services specialist (SSS), and the SFC provider meet to develop a Plan of Action for correcting the ~~concern(s) or violation(s).~~ concerns or violations. The ~~SFC staff~~ DDS SSS notifies the ~~DDSD~~ DDS case manager of the agreed Plan of Action, ~~when the case manager is responsible for monitoring to ensure the Plan of Action is accomplished.~~ The case manager monitors to ensure the Plan is accomplished.

(f) When the provider fails to complete the Plan of Action, the DDS SSS consults the area residential services programs manager to determine if the home should be closed, per OAC 317:40-5-64.

SUBCHAPTER 7. STANDARDS FOR SPECIALIZED FOSTER CARE AND RESPITE HOMES

317:40-7-2. Definitions

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

"**Commensurate wage**" means wages paid to a worker with a disability based on the worker's productivity in proportion to the wages and productivity of workers without a disability performing essentially the same work in the same geographic area. Commensurate wages must

be based on the prevailing wage paid to experienced workers without disabilities doing the same job.

"Competitive integrated employment" means work in the competitive labor market performed on a full-time or part-time basis in integrated community settings. The individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Competitive employment is an individual placement.

"Employment assessment" means the evaluation that identifies the unique preferences, strengths, and needs of members in relation to work. The assessment determines work skills and work behaviors, is supplemented by personal interviews and behavioral observations, and incorporates information that addresses the member's desired medical, physical, psychological, social, cultural, and educational outcomes, as well as present and future employment options. The assessment is updated annually or more frequently as needed, and includes support needs, environmental preferences, and possible accommodations.

"Enhanced rate" means a differential rate established to provide an incentive to provider agencies to provide community employment services to members with significant needs.

"Group placement" means ~~two to eight~~ either two (2) to three (3) workers with disabilities making minimum wage or four (4) to five (5) workers with disabilities who may earn less than minimum wage situated close together, who are provided continuous, long-term training and support in an integrated job site. Members may be employed by the company or by the provider agency. The terms "work crew" and "enclave" also describe a group placement.

"Individual placement in community-based services" means the member is provided supports that enable him or her to participate in approved community-based activities per Oklahoma Administrative Code 317:40-7-5, individually and not as part of a group placement.

"Individual placement in job coaching services" means one member receiving job coaching services, who:

- (A) ~~works~~ Works in an integrated job setting;
- (B) ~~receives~~ Receives minimum wage or more;
- (C) ~~does~~ Does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;
- (D) ~~is~~ Is employed by a community employer or the provider agency; and
- (E) ~~has~~ Has a job description that is specific to his or her work.

"Integrated employment site" means an activity or job that provides regular interaction with people without disabilities, excluding service providers, to the same extent that a worker without disabilities in a comparable position interacts with others.

"Job coach" means an individual who holds a DDS-approved training job coach certification and provides ongoing support services to eligible persons in supported employment placements. Services directly support the member's work activity including marketing and job development, job and work site assessment, training and worker assessment, job matching procedures, development of co-worker natural and paid supports, and teaching job skills.

"Job sampling" means a paid situational assessment whereby a member performs a job at a prospective employer's integrated job site in order to determine the member's interests and abilities. Situational assessments adhere to the Department of Labor (DOL) regulations regarding wages. The Personal Support Team determines the appropriate type and number of situational assessments for each member.

"On-site supports" means a situation in which the job coach is physically at the job site providing job training to a member.

"Situational assessment" means a comprehensive community-based evaluation of the member's functioning in relation to the supported job including the job site, community through which the member must travel to and from the job, and those at the job site, such as the job coach, co-workers, and supervisors.

"Sub-contract with industry" means the provider agency enters into a sub-contract with an industry or business to pay industry employees to provide supports to members. When the industry agrees, the provider agency may contract directly with an industry employee(s) to provide the services. The state continues to pay the provider agency and the agency provides all pertinent information required for persons served by the agency. The Team determines what, if any, training is required for the employees of the industry providing services.

"Supported employment" means competitive work in an integrated work setting with ongoing support services for members for whom competitive employment has not traditionally occurred or was interrupted or intermittent as a result of the member's disabilities.

"Unpaid training" means unpaid experience in integrated employment sites per ~~with DOL regulations~~ Sections 785.27 through 785.32 of Title 29 of the Code of Federal Regulations (29 C.F.R. §§ 785.27 through 785.32). Members do a variety of tasks that do not equal the full job description of a regular worker.

"Volunteer job" means an unpaid activity in which a member freely participates.

317:40-7-22. Value-Based Payments (VBP)

(a) Purpose. Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) provides incentive payments to support a member as he or she moves toward competitive integrated employment. VBPs are intended to further opportunities for Oklahomans with disabilities to live independently and work in competitive integrated employment. VBPs are included in the member's Individual Plan (Plan) and arrangements for this service are made through the DDS case manager. VBPs support members eighteen (18) years of age and older who receive employment services through the:

- (1) In-Home Supports Waiver;
- (2) Homeward Bound Waiver; or
- (3) Community Waiver.

(b) Payment criteria. VBPs support a member as he or she progresses towards competitive employment per the OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. VBPs are paid:

- (1) After a member is employed for fifteen (15) business days;
- (2) When the member is employed a minimum of fifteen (15) hours weekly; and
- (3) In accordance with the limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule.

SUBCHAPTER 9. SELF-DIRECTED SERVICES

317:40-9-1. Self-directed services (SDS)

(a) Applicability. This Section applies to SDS provided through Home and Community-Based Services (HCBS) Waivers operated by the Oklahoma ~~Department of~~ Department of Human Services ~~OKDHS~~ OKDHS Developmental Disabilities Services (DDS).

(b) Member option. Traditional service delivery methods are available for eligible members

who do not elect to self-direct services.

(c) **General information.** SDS are an option for members receiving HCBS through the In-Home Supports Waiver for Adults (~~IHSW-A~~), In-Home Supports Waiver for Children (~~IHSW-C~~), and the Community Waiver when the member lives in a non-residential setting. SDS provides ~~a member~~ members the opportunity to exercise choice and control in identifying, accessing, and managing specific Waiver services and supports in accordance with his or her needs and personal preferences. SDS are Waiver services OKDHS DDS specifies may be directed by the member or representative using employer and budget authority.

(1) SDS may be directed by:

(A) An adult member, when the member has the ability to self-direct;

(B) A member's legal representative including a parent, spouse or legal guardian; or

(C) A non-legal representative who the member or legal representative freely chosen by the member or his or her legal representative chooses.

(2) The person directing services ~~must~~:

(A) ~~Be~~ Is eighteen (18) years of age or older;

(B) ~~Comply~~ Complies with DDS and Oklahoma Health Care Authority (OHCA) rules and regulations;

(C) ~~Complete~~ Completes required DDS training for self-direction;

(D) ~~Sign~~ Signs an agreement with DDS;

(E) ~~Be~~ Is a member or legal representative approved ~~by the member or his or her legal representative~~ to act in ~~the capacity of a representative;~~ a representative capacity;

(F) ~~Demonstrate~~ Demonstrates knowledge and understanding of the member's needs and preferences; and

(G) ~~Not~~ Does not serve as the Self-Directed (SD) ~~Habilitation—Training Specialist~~ habilitation training specialist (HTS) for the member ~~whom~~ when he or she is directing the member's services.

(d) **The SDS program includes:**

(1) The SDS budget. A ~~plan of care~~ Plan of Care (POC) is developed to meet the member's needs without SDS consideration. The member may elect to self-direct part or the entire amount identified for traditional HTS services. This amount is under the member's control and discretion ~~of the member~~ in accordance with this policy and the approved ~~plan of care,~~ POC, and is the allocated amount that may be used to develop the SDS budget. The SDS budget details the specific spending plan for spending.

(A) The SDS budget is developed annually at the time of the annual plan ~~development~~ and updated, ~~as necessary by~~ Individuals who participate in the budget development include, the member, case manager, parent, legal guardian, and others the member invites to participate ~~in the development of the budget.~~

(B) Payment may only be authorized for goods and services (GS) not covered by SoonerCare, or other generic funding sources, and must meet service necessity criteria ~~of service necessity,~~ per Oklahoma Administrative Code (OAC) 340:100-3-33.1.

(C) The member's SDS budget includes the actual cost of administrative activities including fees for financial management services (FMS) ~~performed by a financial management services (FMS)~~ subagent, background checks, workers' compensation insurance, and the amount identified for SD-HTS, SD Job Coaching, and Self-directed goods and services (SD-GS).

(D) The SDS budget is added to the ~~plan of care~~POC to replace any portion of traditional HTS services to be self-directed.

(E) The member's employment services costs, excluding transportation services, cannot exceed limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule, per POC year.

(2) The SD-HTS supports the member's self-care, and the daily living and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being. SD-HTS services must be included in the approved SDS budget. Payment is not made for routine care and supervision that is ~~normally~~typically provided by a family member or the member's spouse. SD-HTS services are provided only during periods when staff is engaged in purposeful activity that directly or indirectly benefits the member. SD-HTS services are limited to a daily average of no more than nine (9) hours per day, per OAC 340:100-5-35. At no time are SD-HTS services authorized for periods ~~during which~~when staff is allowed to sleep. Legally responsible persons may not provide services, per OAC 340:100-3-33.2. Other family members providing services must be employed by provider agencies per OAC 340:100-3-33.2. For the purpose of this rule, family members include parents, siblings, step-parents, step siblings, and anyone living in the same home as the member. Payment does not include room and board, maintenance, or upkeep or improvements to the member's or family's residence. ~~An~~ SD-HTS must:

(A) ~~Be~~Is eighteen (18) years of age; and older;

(B) ~~Pass~~Passes a background check, per OAC 340:100-3-39;

(C) ~~Demonstrate~~Demonstrates competency to perform required tasks;

(D) ~~Complete~~Completes required training, per OAC 340:100-3-38 et seq.;

(E) ~~Sign~~Signs an agreement with DDS and the member;

(F) ~~Be~~Is physically able and mentally alert to carry out the job's duties of the job;

(G) ~~Not~~Does not work as an SD-HTS more than forty (40) hours in any week ~~in the capacity of a SD-HTS;~~

(H) ~~Not~~Does not implement prohibited procedures, per OAC 340:100-5-58;

(I) ~~Provide~~Provides services to only one (1) member at any given time. This does not preclude providing services from being provided in a group setting where services are shared among group members of the group; and

(J) ~~Not~~Does not perform any job duties associated with other employment, including on-call duties, at the same time they are providing SD-HTS services.

(3) SD-Job Coaching services:

(A) Are pre-planned, documented activities related to the member's identified employment outcomes. This includes training at the work site and support by job coach staff who have completed DDS sanctioned training per OAC 340:100-3-38.2;

(B) Promote the member's capacity to secure and maintain integrated employment at the member's chosen job, provided the job pays at or more than minimum wage, or the member is working to achieve minimum wage;

(C) Provide active participation in paid work. Efforts are made in cooperation with employers, and an active relationship with the business is maintained, to adapt normal work environments to fit the member's needs;

(D) Are available for individual placements. Individual placement is one member receiving job coaching services who:

- (i) Works in an integrated job setting;
- (ii) Is paid at or more than minimum wage;
- (iii) Does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;
- (iv) Is employed by a community employer; and
- (v) Has a job description that is specific to the member's work; and

(E) Is authorized when on-site supports by a certified job coach are provided more than twenty (20) percent of the member's compensable work time. Job coaching services rate continues until a member reaches twenty (20) percent or less job coach intervention for four (4) consecutive weeks, at which time stabilization services begin.

(F) Are based on the amount of time the member is compensated by the employer, except per OAC 317:40-7-11;

(G) For members in individual placements, the Personal Support Team (Team):

- (i) Evaluates the job coaching services need at least annually; and
- (ii) Documents a plan for fading job coaching services as the member's independence increases.

(H) In order to participate in individual placement, the individual is found ineligible for services funded through the Department of Rehabilitation Services or have a closed case; and

(I) An SD-Job Coach:

- (i) Is eighteen (18) years of age;
- (ii) Passes a background check per OAC 340:100-3-39;
- (iii) Demonstrates competency to perform required tasks;
- (iv) Completes required training per OAC 340:100-3-38 et seq.;
- (v) Signs an agreement with DDS and the member;
- (vi) Is physically able and mentally alert to carry out job duties;
- (vii) Does not work more than forty (40) hours in any week as an SD-Job Coach or SD-HTS;
- (viii) Does not implement restrictive or intrusive procedures per OAC 340:100-5-57;
- (ix) Provides services to only one member at any given time; and
- (x) Does not perform any job duties associated with other employment including on-call duties at the same time he or she is providing SD-Job Coaching services; and

~~(3)(4)~~ SD-GS are incidental, non-routine goods and services that, and promote the member's self-care, daily living, adaptive functioning, general household activities, meal preparation, and leisure skills needed to reside successfully in the community ~~and~~. SD-GS do not duplicate other services authorized in the member's plan of care-POC. These SD-GS must be included in the ~~individual plan~~ Individual Plan (Plan) and approved SDS budget. SD-GS must meet the requirements listed in (A) through (F)- of this paragraph.

(A) The item or service is justified by a licensed professional's recommendation ~~from a licensed professional~~.

(B) The item or service is not prohibited by federal or state statutes and regulations.

(C) ~~One (1)~~ The item or service meets one (1) or more of the following additional criteria ~~are met~~-listed in (i) through (iii) of this subparagraph. The item or service would:

- (i) ~~Increase~~Increases the member's functioning related to the disability;
 - (ii) ~~Increase~~Increases the member's safety in the home environment; or
 - (iii) ~~Decrease~~Decreases dependence on other SoonerCare funded services.
- (D) SD-GS may include, but are not limited to:
- (i) Fitness items that can be purchased at retail stores;
 - (ii) Short duration camps lasting fourteen (14) consecutive calendar days or less;
 - (iii) A food catcher;
 - (iv) A specialized swing set;
 - (v) Toothettes or an electric toothbrush;
 - (vi) A seat lift;
 - (vii) Weight loss programs or gym memberships when:
 - (I) There is an identified ~~need for~~ need for weight loss or increased physical activity;
 - (II) Justified by outcomes related to weight loss, increased physical activity or stamina; and
 - (III) In subsequent ~~plan of care~~POC year requests, documentation is provided that supports the member's progress toward weight loss ~~or~~, increased physical activity, or stamina; or
 - (viii) Swimming lessons.
- (E) SD-GS ~~may~~is not be used for:
- (i) ~~Co-payments for medical services;~~Medical services co-payments;
 - (ii) Over-the-counter medications;
 - (iii) Items or treatments not approved by the Food and Drug Administration;
 - (iv) Homeopathic services;
 - (v) Services available through any other funding source, such as SoonerCare, Medicare, private insurance, the public school system, rehabilitation services, or natural supports;
 - (vi) Room and board including deposits, rent, and mortgage payments;
 - (vii) Personal items and services not directly related to the member's disability;
 - (viii) Vacation expenses;
 - (ix) Insurance;
 - (x) Vehicle maintenance or other transportation related expense;
 - (xi) Costs related to internet access;
 - (xii) Clothing;
 - (xiii) Tickets and related costs to attend recreational events;
 - (xiv) Services, goods, or supports provided to; the member or benefiting persons other than the member;
 - (xv) Experimental goods or services;
 - (xvi) Personal trainers;
 - (xvii) Spa treatments; or
 - (xviii) Goods or services with costs that significantly exceed community norms for the same or similar goods or services.
- (F) SD-GS are reviewed and approved by the DDS director or designee.
- (e) **Member Responsibilities.** When the member chooses the SDS option, the member or member's representative is the employer of record and ~~must~~:

(1) ~~Enroll and complete~~ Within forty-five (45) calendar days of enrolling in SDS training, the member or member's representatives completes the DDS-sanctioned self-direction training course within forty five (45) calendar days of SDS training enrollment. Exceptions to this timeframe may be approved by the DDS director or his/her designee. The training ~~must be~~ is completed prior to the ~~implementation of self-direction and covers:~~ implementing SD. The training covers:

- (A) Staff recruitment;
 - (B) Hiring of staff as an employer of record;
 - (C) Staff orientation and instruction;
 - (D) Staff supervision including scheduling and service provisions;
 - (E) Staff evaluation;
 - (F) Staff discharge;
 - (G) ~~Philosophy of self-direction;~~ SD philosophy
 - (H) ~~OHCA SD policy on self-direction;~~
 - (I) Individual budgeting;
 - (J) ~~Development of a self-directed~~ SD support plan; development;
 - (K) Cultural diversity; and
 - (L) Rights, risks, and responsibilities., and
- (2) ~~Sign~~ Signs an agreement with DDS;
- (3) ~~Agree~~ Agrees to utilize the ~~services of a FMS subagent;~~ services;
- (4) ~~Agree~~ Agrees to pay administrative costs for background checks, FMS subagent ~~fee, fees,~~ and workers' compensation insurance from his or her SDS budget;
- (5) ~~Comply~~ Complies with federal and state employment laws and ~~ensure~~ ensures no employee works more than forty (40) hours per week in ~~the capacity of an SD-HTS;~~ capacity;
- (6) ~~Ensure~~ Ensures that each employee is qualified to provide the services for which he or she is employed to do and that all billed services are actually provided;
- (7) ~~Ensure~~ Ensures that each employee complies with all DDS training requirements per OAC 340:100-3-38 et seq.;
- (8) ~~Recruit, hire, supervise, and discharge~~ Recruits, hires, supervises, and discharges all employees providing ~~self-directed services;~~ SDS, when necessary;
- (9) ~~Verify~~ Verifies employee qualifications;
- (10) ~~Obtain~~ Obtains background screenings on all employees providing SD-HTS services per OAC 340:100-3-39;
- (11) ~~Send~~ Sends progress reports per OAC 340:100-5-52.
- (12) ~~Participate~~ Participates in the ~~Individual~~ Plan and SDS budget process;
- (13) ~~Immediately notify~~ Notifies the DDS case manager of any emergencies or changes in circumstances that may require modification of the type or amount of services provided for in the member's ~~Individual~~ Plan or SDS budget;
- (14) ~~Wait~~ Waits for budget modification approval ~~of budget modifications~~ before implementing changes;
- (15) ~~Comply~~ Complies with DDS and OHCA administrative rules;
- (16) ~~Cooperate~~ Cooperates with DDS monitoring requirements per OAC 340:100-3-27;
- (17) ~~Cooperate~~ Cooperates with FMS subagent requirements to ensure accurate records and prompt payroll processing including:
- (A) Reviewing and signing employee time cards;

- (B) Verifying the accuracy of hours worked; and
 - (C) Ensuring the appropriate ~~expenditure of funds;~~fund expenditures; and
 - (18) ~~Complete~~Completes all required documents within established timeframes;
 - (19) ~~Pay~~Pays for services incurred in excess of the budget amount;
 - (20) ~~Pay~~Pays for services not identified and approved in the member's SDS budget;
 - (21) ~~Pay~~Pays for services provided by an unqualified provider;
 - (22) ~~Determine~~Determines staff duties, ~~qualifications, and specify~~ and qualifications and specifies service delivery practices consistent with SD-HTS Waiver service specifications;
 - (23) ~~Orient and instruct~~Orients and instructs staff in duties;
 - (24) ~~Evaluate~~Evaluates staff performance;
 - (25) ~~Identify and train~~Identifies and trains back-up staff, when required;
 - (26) ~~Determine~~Determines amount paid for services within plan limits;
 - (27) ~~Schedule~~Schedules staff and ~~the provision of services;~~the services provisions;
 - (28) ~~Ensure~~Ensures SD-HTS do not implement prohibited procedures per OAC 340:100-5-58; and
 - (29) ~~Sign~~Signs an agreement with the SD-HTS.
- (f) **FMS.** The FMS subagent is an entity ~~designated that DDS designates~~ as an agent by DDS to act on behalf of members who have a member's behalf who has employer and budget authority. ~~for the~~The FMS subagent's purpose of managing is to manage payroll tasks for the member's employee(s) and ~~for making payment of SD-GS payments~~ as authorized in the member's plan. FMS subagent duties include, but are not limited to:
- (1) Compliance with all DDS and OHCA administrative rules and contract requirements;
 - (2) Compliance with DDS or OHCA random and targeted audits;
 - (3) Tracking individual expenditures and monitoring SDS budgets;
 - (4) Processing the member's employee payroll, withholding, filing and paying of applicable federal, state, and local employment-related taxes and insurance;
 - (5) ~~Collection and process of employee's~~Employee time sheets collection and processing and making payment to member's employees;
 - (6) ~~Processing and payment of invoices for SD-GS~~ invoice collection and processing as authorized in the member's SDS budget;
 - (7) Providing each member with information that assists with the SDS budget management;
 - (8) Providing reports ~~to members/representatives;~~members and member representatives, as well as providing monthly reports to DDS and to OHCA upon request;
 - (9) Providing DDS and OHCA authorities access to individual member's accounts through a web-based program;
 - (10) Assisting members in verifying employee citizenship status;
 - (11) Maintaining separate accounts for each member's SDS budget;
 - (12) Tracking and reporting member funds, balances, and disbursements;
 - (13) Receiving and disbursing funds for SDS payment per OHCA agreement; and
 - (14) Executing and maintaining a contractual agreement between DDS and the SD-HTS (employee).
- (g) **DDS case management responsibilities in support of SDS.**
- (1) The DDS case manager develops the member's plan per OAC 340:100-5-50 through 340:100-5-58;

(2) The DDS case manager meets with the member, or, when applicable, the member's representative, or legal guardian, when applicable, to discuss the Waiver service delivery options in (A) and (B) of this paragraph:

(A) Traditional Waiver services; and

(B) ~~Self-directed services~~SDS including information regarding scope of choices, options, rights, risks, and responsibilities associated with ~~self-direction~~SDS.

(3) When the member chooses ~~self-direction~~SDS, the DDS case manager:

(A) Discusses ~~with member or representative~~ the available amount in the budget; with the member or the member's representative;

(B) Assists the member or representative ~~with the development~~in developing and ~~modification of~~modifying the SDS budget;

(C) Submits request for SD-GS to the DDS director or designee for review and approval;

~~(D) Develops the SDS budget and modifications;~~

~~(E)~~(D) Assists the member or representative ~~develop or revise~~developing or revising an emergency back-up plan;

~~(F)~~(E) Monitors plan implementation ~~of the plan~~ per OAC 340:100-3-27;

~~(G)~~(F) Ensures services are initiated within required time frames;

~~(H)~~(G) Conducts ongoing monitoring of plan implementation and of the member's health and welfare; and

~~(I)~~(H) Ensures the SD-HTS does not implement prohibited procedures, per OAC 340:100-5-58 ~~are not implemented by the SD-HTS~~. If the Team determines restrictive or intrusive procedures are necessary to address behavioral challenges, requirements must be met, per OAC 340:100-5-57.

(h) **Government fiscal/employer agent model.** DDS serves as the Organized Health Care Delivery System (OHCD) and FMS provider in a Centers for Medicare and Medicaid Services (~~CMS~~) approved government fiscal/employer agent model. DDS has an interagency agreement with OHCA.

(i) **Voluntary termination of self-directed services.** Members may discontinue ~~self-directing services~~SDS without disruption at any time, provided traditional Waiver services are in place. Members or representatives may not choose the ~~self-directed~~SDS option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next ~~plan of care~~POC. A member desiring to file a complaint must follow procedures per OAC 340:2-5-61.

(j) **~~Involuntary termination of self-directed services.~~SDS involuntary termination.**

(1) Members may be involuntarily terminated from ~~self-direction~~SDS and offered traditional Waiver services when ~~it has been determined by the DDS director or designee that any of the following exist;~~the DDS director or designee has determined that any of the criteria in

(A) through (F) of this paragraph exist:

(A) Immediate health and safety risks associated with self-direction, such as, imminent risk of death or irreversible or serious bodily injury related to Waiver services;

(B) Intentional misuse of funds following notification, assistance and support from DDS;

(C) Failure to follow and implement policies of self-direction after receiving DDS technical assistance and guidance;

(D) ~~Fraud;~~Suspected fraud or abuse of funds;

(E) A member no longer receives a minimum of one (1) SDS Waiver service per month and DDS is unable to monitor the member; or

(F) Reliable information shows the employer of record or SD-HTS engaged in illegal activity.

(2) When action is taken to involuntarily terminate the member from ~~self-directed services, SDS~~, the case manager assists the member ~~access~~in assessing needed and appropriate services through the traditional Waiver services option; ~~ensuring~~The case manager ensures that no lapse in necessary services occurs for which the member is eligible.

(3) The Fair Hearing process, per OAC 340:100-3-13 applies.

(k) **Reporting requirements.** While operating as an OHCD, DDS provides OHCA reports detailing provider activity in the format and at times OHCA requires.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **Compensable services.** Providers may be reimbursed for compensable clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from Centers for Medicare and Medicaid Services and have a current contract on file with the Oklahoma Health Care Authority (OHCA). Providers performing laboratory services must have the appropriate CLIA certification specific to the level of testing performed.

(B) Only medically necessary laboratory services are compensable.

(i) Testing must be medically indicated as evidenced by patient-specific indications in the medical record.

(ii) Testing is only compensable if the results will affect patient care and are performed to diagnose conditions and illnesses with specific symptoms.

(iii) Testing is only compensable if the services are performed in furtherance of the diagnosis and/or treatment of conditions that are covered under SoonerCare.

(C) Laboratory testing must be ordered by the physician or non-physician provider, and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(D) Laboratory testing for routine diagnostic or screening tests following clinical guidelines such as those found in the American Academy of Pediatrics (AAP) Bright Futures' periodicity schedule, the United States Preventive Services Task Force (USPSTF) A and B recommendations, the American Academy of Family Practitioners (AAFP), or other nationally recognized medical professional academy or society standards of care, is compensable. Additionally, such sources as named in this subdivision should meet medical necessity criteria as outlined in Oklahoma Administrative Code (OAC) 317:30-3-1(f).

(2) **Non-compensable laboratory services.**

(A) Laboratory testing for routine diagnostic or screening tests not supported by the clinical guidelines of a nationally recognized medical professional academy or society standard of care, and/or testing that is performed without apparent relationship to treatment or diagnosis of a specific illness, symptom, complaint or injury is not covered.

(B) Non-specific, blanket panel or standing orders for laboratory testing, ~~custom panels particular to the ordering provider~~, or lab panels which have no impact on the patient's plan of care are not covered.

(C) Split billing, or dividing the billed services for the same patient for the same date of service by the same rendering laboratory into two (2) or more claims is not allowed.

(D) ~~Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.~~ Separate payment is not made for blood specimens obtained by venipuncture, arterial puncture, or urine specimens collected by a provider who is also performing the laboratory testing as these services are considered part of the laboratory analysis.

(E) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(F) Billing multiple units of nucleic acid detection for individual infectious organisms when testing for more than one (1) infectious organism in a specimen is not permissible. Instead, OHCA considers it appropriate to bill a single unit of a procedure code indicated for multiple organism testing.

(G) Billing multiple Current Procedural Terminology (CPT) codes or units for molecular pathology tests that examine multiple genes or incorporate multiple types of genetic analysis in a single run or report is not permissible. Instead, OHCA considers it appropriate to bill a single CPT code for such test. If an appropriate code does not exist, then one (1) unit for an unlisted molecular pathology procedure may be billed.

(3) Covered services by a pathologist.

(A) A pathologist may be paid for the interpretation of inpatient surgical pathology specimen when the appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or ambulatory surgery center setting.

(4) Non-compensable services by a pathologist. The following are non-compensable pathologist services:

(A) Experimental or investigational procedures. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(B) Interpretation of clinical laboratory procedures.

317:30-5-20.1. Drug screening and testing

(a) **Purpose.** Drug Testing is performed for undisclosed drug use and/or abuse, and to verify compliance with treatment. Testing for drugs of abuse to monitor treatment compliance should be included in the treatment plan for pain management when chronic opioid therapy is involved.

(1) Qualitative (presumptive) drug testing may be used to determine the presence or absence of a drug or drug metabolite in the sample and is expressed as a positive or negative result. Qualitative testing can be performed by a CLIA waived or moderate complexity test, or by a high complexity testing method.

(2) Quantitative (definitive) drug testing is specific to the drug or metabolite being tested and is expressed as a numeric result or numeric level which verifies concentration.

(3) Specimen validity testing is used to determine if a specimen has been diluted, adulterated or substituted. Specimen validity tests include, but are not limited to, creatinine, oxidants, specific gravity, urine pH, nitrates and alkaloids.

(b) **Eligible providers.** Providers performing drug testing should have CLIA certification specific to the level of testing performed as described in 317:30-5-20(1)(A).

(c) **Compensable services.** Drug testing must be ordered by the physician or non-physician provider and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(1) Compensable testing must be medically indicated as evidenced by patient specific indications in the medical record.

(A) Testing is only compensable if the results will affect patient care.

(B) Drugs or drug classes being tested should reflect only those likely to be present.

(2) The frequency of drug screening and/or testing is determined by the patient's history, patient's physical assessment, behavioral assessment, risk assessment, treatment plan and medication history.

(3) Quantitative (definitive) drug testing may be indicated for the following:

(A) To identify a specific substance or metabolite that is inadequately detected or undetectable by a qualitative (presumptive) test; or

(B) To definitively identify specific drugs in a large family of drugs; or

(C) To identify drugs when a definitive concentration of a drug is needed to guide management; or

(D) To identify a negative, or confirm a positive, qualitative (presumptive) result that is inconsistent with a patient's self-report, presentation, medical history or current prescribed medication plan; or

(E) To identify a non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances.

(d) **Non-compensable services.** The following tests are not medically necessary and therefore not covered by the OHCA:

(1) Specimen validity testing is considered a quality control measure and is not separately compensable;

(2) Drug testing for patient sample sources of saliva, oral fluids, or hair;

(3) Testing of two different specimen types (urine and blood) from the same patient on the same date of service;

(4) Drug testing for medico-legal purposes (court ordered drug screening) or for employment purposes;

(5) Non-specific, blanket panel or standing orders for drug testing, ~~custom panels specific for the ordering provider~~, routine testing of therapeutic drug levels, or drug panels which have no impact to the member's plan of care;

(6) Scheduled and routine drug testing (i.e. testing should be random);

(7) Reflex testing for any drug is not medically indicated without specific documented indications;

(8) Confirmatory testing exceeding three specific drug classes at an interval of greater than every thirty (30) days will require specific documentation in the medical record to justify the medical necessity of testing; and

(9) Quantitative (definitive) testing of multiple drug levels that are not specific to the patient's medical history and presentation are not allowed. Justification for testing for each individual drug or drug class level must be medically indicated as reflected in the medical record documentation.

(e) **Documentation requirements.** The medical record must contain documents to support the medical necessity of drug screening and/or testing. Medical records must be furnished on request and may include, but are not limited to, the following:

- (1) A current treatment plan;
- (2) Patient history and physical;
- (3) Review of previous medical records if treated by a different physician for pain management;
- (4) Review of all radiographs and/or laboratory studies pertinent to the patient's condition;
- (5) Opioid agreement and informed consent of drug testing, as applicable;
- (6) List of prescribed medications;
- (7) Risk assessment, as identified by use of a validated risk assessment tool/questionnaire, with appropriate risk stratification noted and utilized;
- (8) Office/provider monitoring protocols, such as random pill counts; and
- (9) Review of prescription drug monitoring data or pharmacy profile as warranted.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and cost sharing

(a) **Definitions.** The following words and terms, when used in subsection (c) of this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "**Fee-for-service (FFS) contract**" means the provider agreement specified in Oklahoma Administrative Code (OAC) 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority (OHCA) and medical providers which provides for a fee with a specified service involved.

(2) "**Outside of the scope of the services**" means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

~~(2)(3)~~ (3) "**Within the scope of services**" means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

~~(3)~~ "**Outside of the scope of the services**" means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

(b) **Assignment in ~~fee-for-service~~FFS.** Oklahoma's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a ~~fee-for-service~~FFS contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the OHCA shall be the final authority for this decision.

(3) Violation of this provision shall be grounds for a contract termination in the ~~fee-for-service~~FFS and SoonerCare programs.

(d) **Cost sharing/co-payment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the ~~fee-for-service~~FFS program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges, and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age twenty-one (21). Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(C) Home and Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) American Indian and Alaska Native members, per Section 5006 of the American Recovery and Reinvestment Act of 2009 and as established in the federally-approved Oklahoma Medicaid State Plan.

(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer Treatment program.

(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

(2) Co-payment is not required for the following services:

(A) Family planning services. This includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, ~~if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, including prenatal vitamins.~~

(D) Smoking and tobacco cessation counseling and products.

(E) Blood glucose testing supplies and insulin syringes.

(F) Medication-assisted treatment (MAT) drugs.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians;

- (ii) Advanced practice registered nurses;
- (iii) Physician assistants;
- (iv) Optometrists;
- (v) Home health agencies;
- (vi) Certified registered nurse anesthetists;
- (vii) Anesthesiologist assistants;
- (viii) Durable medical equipment providers; and
- (ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.

(5) Providers will be required to refund any co-payment amounts the provider collected from the member in error and/or above the family's aggregate cost sharing maximum.

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**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 1. ADMINISTRATIVE OPERATIONS**

SUBCHAPTER 1. ORGANIZATION AND ADMINISTRATION

317:1-1-2. Authority and amending of rules

(a) The authority for the rules in this Title is the Oklahoma Health Care Authority Act. The Act is in Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes. The rules in this Chapter are promulgated by the Authority to establish the Authority's organization and its administration, policies and procedures.

(b) This title may be amended or repealed from time to time and new rules and regulations adopted by the Authority pursuant to the Administrative Procedures Act.

317:1-1-3. Amending of rules [REVOKED]

~~This title may be amended or repealed from time to time and new rules and regulations adopted by the Authority pursuant to the Administrative Procedures Act.~~

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

SUBCHAPTER 1. GENERAL PROVISIONS

317:30-1-1. Purpose; use of manuals

The purpose of this Chapter is to detail rules applicable to providers of medical services purchased by the Oklahoma Health Care Authority. Subchapters one, three and seven are applicable to all medical providers, while Subchapter five consists of rules unique to a specific type of provider, services or specialty. As a convenience to providers, the Authority compiles applicable Subchapters and Sections into manuals which are available to providers at no cost.

(a) The purpose of this Chapter is to detail rules applicable to providers of medical services purchased by the Oklahoma Health Care Authority (OHCA).

(b) This Chapter contains basic information concerning the SoonerCare Program. It is intended for use by all providers of medical and health related services participating in the program. Subchapters one, three and seven are applicable to all medical providers, while Subchapter five consists of rules unique to a specific type of provider, services, or specialty.

(1) The Chapter contains Sections dealing with provider policies, coverage of medical and health services, and other general program policies and procedures applicable to all providers.

(2) Providers and their office staff are urged to familiarize themselves with the contents of this Chapter and to refer to it when questions arise. Use of the Chapter will reduce misunderstandings concerning the coverage and reimbursement of SoonerCare services and the Agency's expectations of providers. As users of the rules in this Chapter, OHCA also solicits suggestions and comments from providers.

(c) As a convenience to providers, the Authority compiles applicable Subchapters and Sections into policy documents which are available to providers at no cost.

317:30-1-3. Description of rules [REVOKED]

~~How to use this Chapter. This Chapter contains basic information concerning the SoonerCare Program. It is intended for use by all providers of medical and health related services participating in the program. Subchapters one, three and seven are applicable to all medical providers, while Subchapter five consists of rules unique to a specific type of provider, services or specialty.~~

~~(1) The Chapter contains Sections dealing with provider policies, coverage of medical and health services, and other general program policies and procedures applicable to all providers.~~

~~(2) Providers and their office staff are urged to familiarize themselves with the contents of this Chapter and to refer to it when questions arise. Use of the Chapter will reduce misunderstandings concerning the coverage and reimbursement of SoonerCare services and the Agency's expectations of providers. As users of the rules in this Chapter, OHCA also solicits suggestions and comments from providers.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-40.2. Definitions [REVOKED]

~~The following words and terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise.~~

~~"CMS" means the Center for Medicare and Medicaid Services~~

~~"Diagnosis Related Group" means a patient classification system that relates types of patients treated to the resources they consume.~~

PART 27. INDEPENDENT PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

317:30-5-291. Coverage by category; payment rates and procedure codes

(a) Coverage. Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed physical therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code (OAC) 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

(b) Payment rates. All physical therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

(c) Procedure codes. The appropriate procedure codes used for billing physical therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.

317:30-5-291.1. Payment rates [REVOKED]

~~All physical therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.~~

317:30-5-291.2. Procedure codes [REVOKED]

~~The appropriate procedure codes used for billing physical therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.~~

PART 28. OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

317:30-5-296. Coverage by category; payment rates and procedure codes

(a) Coverage. Payment is made for occupational therapy services as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed occupational therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy

services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code (OAC) 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

(b) **Payment rates.** All occupational therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

(c) **Procedure codes.** The appropriate procedure codes used for billing occupational therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.

317:30-5-297. Payment rates [REVOKED]

~~All occupational therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.~~

317:30-5-298. Procedure codes [REVOKED]

~~The appropriate procedure codes used for billing occupational therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.~~

PART 73. EARLY INTERVENTION SERVICES

317:30-5-640.1. Periodicity schedule

(a) The Oklahoma Health Care Authority requires that all physicians providing reimbursable Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) screens adopt and utilize the American Academy of Pediatrics and Bright Futures periodicity schedule.

(b) Medicaid-eligible children and adolescents enrolled in SoonerCare are referred to their SoonerCare provider for EPSDT screens. In cases where the SoonerCare provider authorizes the qualified provider of health related services to perform the screen or fails to schedule an appointment within three (3) weeks and a request has been made and documented by the staff of the Oklahoma State Department of Education and Oklahoma State Department of Health (OSDH), or the latter's contractors, the OSDH may then furnish the EPSDT child-health screening and bill it as a fee-for-service (FFS) activity. Results of the child-health screening are forwarded to the member's SoonerCare provider.

(c) For periodic and interperiodic screening examination, please refer to Oklahoma Administrative Code 317:30-3-65 through 317:30-3-65.12.

317:30-5-641.1. Periodic and interperiodic screening examination [REVOKED]

~~Refer to Oklahoma Administrative Code 317:30-3-65 through 317:30-3-65.12.~~

PART 77. SPEECH-LANGUAGE PATHOLOGISTS, SPEECH-LANGUAGE PATHOLOGY ASSISTANTS, CLINICAL FELLOWS AND AUDIOLOGISTS

317:30-5-676. Coverage by category; payment rates and procedure codes

(a) Coverage. Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** All therapy services, including the initial evaluation, must be prior authorized. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

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

(i) Speech-language pathology services may include speech-language evaluations, individual and group therapy services provided by a fully licensed and certified speech-language pathologist, a licensed speech-language pathology clinical fellow, and services within the scope of practice of a speech-language pathology assistant as directed by the supervising speech-language pathologist, as listed in Oklahoma Administrative Code (OAC) 317:30-5-675 (a) through (c).

(ii) Initial evaluations must be prior authorized and provided by a fully licensed speech-language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a ~~Medical or Osteopathic~~ medical or osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in OAC 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

(b) Payment rates. All speech-language pathology and hearing services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

(c) Procedure codes. The appropriate procedure codes used for billing speech and hearing services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.

317:30-5-677. Payment rates [REVOKED]

~~All speech language pathology and hearing services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.~~

317:30-5-678. Procedure codes [REVOKED]

~~The appropriate procedure codes used for billing speech and hearing services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.~~

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1023. Coverage by category

(a) **Adults.** There is no coverage for services rendered to adults twenty-one (21) years of age and older.

(b) **Children.** For non-Individualized Education Program (IEP) medical services that can be provided in a school setting, refer to Part 4, ~~Early and Periodic Screening, Diagnostic and Treatment program~~ Early And Periodic Screening, Diagnostic and Treatment (EPSDT) Program/Child-Health Services, of Oklahoma Administrative Code (OAC) at 317:30-3-65 through ~~317:30-3-63.12~~ 317:30-3-65.12. Payment is made for the following compensable services rendered by qualified school providers:

(1) **Diagnostic encounters.** Diagnostic encounters are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses, or conditions discovered by the screening. Approved diagnostic encounters may include the following:

(A) **Hearing and hearing aid evaluation.** Hearing evaluation includes pure tone air, bone, and speech audiometry. Hearing evaluations must be provided by a state-licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

(B) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state-licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

(C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking an impression of a member's ear and providing a finished earmold, to be used with the member's hearing aid as provided by a state-licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

(D) **Vision screening.** Vision screening in schools includes application of tests and examinations to identify visual defects or vision disorders. The vision screening may be performed by a ~~Registered Nurse~~ registered nurse (RN) or Licensed Practical Nurse licensed practical nurse (LPN) under the supervision of an RN. The service can be billed when a SoonerCare member has an individualized documented concern that warrants a screening. A vision examination must be provided by a state-licensed ~~Doctor of Optometry~~ doctor of optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). This vision examination, at a minimum, includes diagnosis and treatment for defects in vision.

(E) **Speech-language evaluation.** Speech-language evaluation is for the purpose of identification of children or adolescents with speech or language disorders and the diagnosis and appraisal of specific speech and language services. Speech-language evaluations must be provided by a fully licensed speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3).

(F) **Physical therapy evaluation.** Physical therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems. It must be provided by a fully licensed physical therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2). Physical therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) **Occupational therapy evaluation.** Occupational therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a fully licensed occupational therapist as listed in OAC 317:30-5-295 (a) (1) and (2). Occupational therapy evaluations must adhere to guidelines found at OAC 317:30-5-296.

(H) **Evaluation and testing.** Evaluation and testing by psychologists and certified school psychologists are for the purpose of assessing emotional, behavioral, cognitive, or developmental issues that are affecting academic performance and for determining recommended treatment protocol. Evaluation or testing for the sole purpose of academic placement (e.g., diagnosis of learning disorders) is not a compensable service. These evaluations and tests must be provided by a state-licensed, board-certified psychologist or a certified school psychologist certified by the State Department of Education (SDE).

(2) **Child-guidance treatment encounter.** A child-guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children and adolescents who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP and may include the following:

(A) **Hearing and vision services.** Hearing and vision services may include provision of habilitation activities, such as: auditory training; aural and visual habilitation training including Braille, and communication management; orientation and mobility; and counseling for vision and hearing losses and disorders. Services must be provided by or under the direct guidance of one (1) of the following individuals practicing within the scope of his or her practice under state law:

- (i) State-licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).
- (ii) Fully licensed, speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3).
- (iii) Certified orientation and mobility specialists.

(B) **Speech-language therapy services.** Speech-language therapy services include provisions of speech and language services for the habilitation or prevention of communicative disorders. Speech-language therapy services must be provided by or under the direct guidance and supervision of a fully licensed speech-language pathologist within the scope of his or her practice under state law as listed in OAC 317:30-5-675 (a) (1) through (3).

(C) **Physical therapy services.** Physical therapy services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affect the member's education. Physical therapy services must adhere to guidelines found at OAC 317:30-5-291 and must be provided by or under the direct guidance and supervision of a fully licensed physical therapist; services may also be provided by a licensed physical therapy assistant who has been authorized by the Board of Examiners working under the supervision of a fully licensed physical therapist.

(D) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop, or restore impaired ability to function independently. Occupational therapy services must be provided by or under the direct guidance and supervision of a fully licensed occupational therapist; services may also be provided by a licensed occupational therapy assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed occupational therapist.

(E) **Nursing services.** Nursing services may include provision of services to protect the health status of children and adolescents, correct health problems and assist in removing or modifying health-related barriers, and must be provided by a RN or LPN under supervision of a RN. Services include medically necessary procedures rendered at the

school site, such as catheterization, suctioning, tube feeding, and administration and monitoring of medication.

(F) **Counseling services.** All services must be for the direct benefit of the member. Counseling services must be provided by a state-licensed social worker, a state-licensed professional counselor, a state-licensed psychologist or SDE-certified school psychologist, a state-licensed marriage and family therapist, or a state-licensed behavioral health practitioner, or under Board supervision to be licensed in one (1) of the above-stated areas.

(G) **Assistive technology.** Assistive technology is the provision of services that help to select a device and assist a student with disability(ies) to use an assistive technology device, including coordination with other therapies and training of member and caregiver. Services must be provided by a:

- (i) Fully licensed speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3);
- (ii) Fully licensed physical therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2); or
- (iii) Fully licensed occupational therapist as listed in OAC 317:30-5-295 (a) (1) and (2).

(H) **Personal care.** Provision of personal care services (PCS) allow students with disabilities to safely attend school. Services include, but are not limited to: dressing, eating, bathing, assistance with transferring and toileting, positioning, and instrumental activities of daily living such as preparing meals and managing medications. PCS also includes assistance while riding a school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals that have completed training approved or provided by SDE, or personal care assistants, including LPNs, who have completed on-the-job training specific to their duties. PCS does not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a RN or LPN. Catheter insertion and ~~Catheter/Ostomy~~catheter/ostomy care may only be reimbursed when done by a RN or LPN. All PCS must be prior authorized.

(I) **Therapeutic behavioral services (TBS).** Services are goal-directed activities for each client to restore, retain and improve the self-help, socialization, communication, and adaptive skills necessary to reside successfully in home and community-based settings. It also includes problem identification and goal setting, medication support, restoring function, and providing support and redirection when needed. TBS activities are behavioral interventions to complement more intensive behavioral health services and may include the following components: basic living and self-help skills; social skills; communication skills; organization and time management; and transitional living skills. This service must be provided by a behavioral health school aide (BHSA) who has a high school diploma or equivalent and has successfully completed training approved by the SDE, and in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), along with corresponding continuing education. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have ~~CPR~~Cardiopulmonary resuscitation (CPR) and ~~First Aid~~first aid certification. Six (6) additional hours of related continuing education are

required per year.

(c) **Members eligible for Part B of Medicare.** EPSDT school health-related services provided to Medicare eligible members are billed directly to the fiscal agent.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to RHCs for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one (1) encounter per member per day. Payment is also limited to four (4) visits per member per month. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. Preventive service exceptions include:

(A) **Obstetrical care.** An RHC should have a written contract with its physician, PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for RHC and other ambulatory services.

(i) If the clinic compensates the physician, PA, APRN, or CNM to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, PAs, APRNs and CNMs (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.

(2) **Other ambulatory services.** These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows:

(A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors.

(B) There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one (1) encounter per member per day. Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the

member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. RHCs must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

- (1) **RHC.** The appropriate revenue code is required. No HCPCS or CPT code is required.
- (2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.
- (3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.
- (4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.
- (5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the CPT Manual. Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist for members under the age of twenty-one (21).
- (6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.
 - (A) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.
 - (B) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.
- (7) **Visual analysis.** Visual analysis services for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Visual analysis services are billed using the appropriate revenue code and a HCPCS code. Payment is made directly to the RHC on an encounter basis for on-site optometric services by a licensed optometrist for members under the age of twenty-one (21).

(b) **Services billed separately from encounters.**

- (1) Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges from the physical location where services were rendered/performed.
 - (A) **Laboratory.** The RHC must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.
 - (B) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.
 - (C) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.
 - (D) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required.

(E) **Eyeglasses.** Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two eyeglasses per year. Any eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.

(2) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.3. FQHC encounters

(a) FQHC encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a PPS encounter rate.

(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour period ending at midnight, as documented in the member's medical record.

(c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to OAC 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.

(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

- (1) Medical;
- (2) Diagnostic;
- (3) Dental, medical and behavioral health screenings;
- (4) Vision;
- (5) Physical therapy;
- (6) Occupational therapy;
- (7) Podiatry;
- (8) Behavioral health;
- (9) Speech;
- (10) Hearing;
- (11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
- (12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP and CSW are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

**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

317:30-5-241.7. Medication-assisted treatment (MAT) services for eligible individuals with opioid use disorder (OUD)

(a) **Definitions.** The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "**Medication-assisted treatment (MAT)**" means an evidence-based practice approved by the Food and Drug Administration (FDA) to treat opioid use disorder, including methadone and all biological products licensed under federal law for such purpose. MAT also includes the provision of counseling and behavioral therapy.

(2) "**Office-based opioid treatment (OBOT)**" means a fully contracted SoonerCare provider that renders MAT services in OBOT settings. OBOT providers must have capacity to provide all drugs approved by the FDA for the treatment of opioid use disorder, directly or by referral, including for maintenance, detoxification, overdose reversal, and relapse prevention, and appropriate counseling and other appropriate ancillary services.

(3) "**Opioid treatment program (OTP)**" means a program or provider:

(A) Registered under federal law;

(B) Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA);

(C) Certified by ODMHSAS, unless deemed an exempted entity as defined by federal law;

(D) Registered by the Drug Enforcement Agency (DEA);

(E) Registered by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD); and

(F) Engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone.

(4) "**Opioid use disorder (OUD)**" means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opioids despite significant opioid-induced problems.

(5) "**Phase I**" means a minimum ninety (90) day period in which the member attends the opioid treatment program for observation of medication assisted treatment daily or at least six (6) days a week.

(6) "**Phase II**" means the phase of treatment for members who have been admitted for more than ninety (90) days and who have successfully completed Phase I.

(7) "**Phase III**" means the phase of treatment for members who have been admitted for more than six (6) months and who have successfully completed Phase II.

(8) "**Phase IV**" means the phase of treatment for members who have been admitted for more than nine (9) months and who have successfully completed Phase III.

(9) "**Phase V**" means the phase of treatment for members who have been admitted for more than one (1) year.

(10) "**Phase VI**" means the phase of treatment for members who voluntarily seek medically supervised withdrawal and abstinence from all drugs, including methadone as prescribed. A member may enter this phase at any time in the treatment and rehabilitation process.

(b) **Coverage.** The SoonerCare program provides coverage of medically necessary MAT services in

OTPs, including but not limited to, methadone treatment, to eligible individuals with OUD. An OTP must have the capacity to provide the full range of services included in the definition of MAT and must document both medication dosing and supporting behavioral health services, including but not limited to, individual, family and group therapy and rehabilitation services. MAT services and/or medications may also be provided in OBOT settings per OAC 317:30-5-9(b)(17).

(c) **OTP requirements.** Every OTP provider shall:

- (1) Have a current contract with the OHCA as an OTP provider;
- (2) Hold a certification as an OTP from ODMHSAS, unless deemed an exempted entity as defined by federal law;
- (3) Hold a certification from the Substance Abuse and Mental Health Services Administration (SAMHSA);
- (4) Be appropriately accredited by a SAMHSA-approved accreditation organization;
- (5) Be registered with the DEA and the OBNDD; and
- (6) Meet all state and federal opioid treatment standards, including all requirements within OAC 450:70.

(d) **Individual OTP providers.** OTP providers include a:

- (1) ~~MAT provider~~ MAT provider who is a physician, physician's assistant (PA), or advanced practice registered nurse (APRN) who may prescribe, dispense, and administer medications in accordance with state and federal law and the Oklahoma Medicaid State Plan.
- (2) ~~OTP behavioral health services practitioner is~~ OTP behavioral health services practitioner who is a practitioner that meets the qualifications in OAC 317:30-5-240.3, except for family support and training providers, qualified behavioral therapy aide providers, multi-systemic therapy providers, and case manager I providers, for the provision of outpatient behavioral health services.

(e) **Intake and assessment.** OTPs shall conduct intake and assessment procedures in accordance with OAC 450:70-3-5 through OAC 450:70-3-7.

(f) **Service phases.** In accordance with OAC 450:70-6-17.2 through OAC 450:70-6-17.8, the OTP shall have structured phases of treatment and rehabilitation to support member progress and to establish requirements regarding member attendance and service participation. The OTP shall utilize ASAM criteria to determine the appropriate level of care during each phase of treatment. Treatment requirements for each phase shall include, but not limited to, the following:

- ~~(1) During phase I, the member shall participate in a minimum of four (4) sessions of therapy or rehabilitation services per month with at least one (1) session being individual therapy, rehabilitation, or case management.~~
- ~~(2) During phase II the member shall participate in at least two (2) therapy or rehabilitation service sessions per month during the first ninety (90) days, with at least one (1) of the sessions being individual therapy, rehabilitation, or case management. After the initial ninety (90) days in Phase II, the member shall participate in at least one (1) session of individual therapy or rehabilitation service per month.~~
- ~~(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) session of individual therapy, rehabilitation, or case management per month.~~
- (1) During phase I, the member shall participate in a minimum of four (4) treatment sessions per month, including, but not exclusive to, therapy, rehabilitation, case management, and peer recovery support services.

- (2) During phase II, the member shall participate in at least two (2) treatment sessions per month during the first ninety (90) days, including, but not exclusive to, therapy, rehabilitation,

case management, and peer recovery support services. After the initial ninety (90) days in Phase II, the member shall participate in at least one (1) treatment session per month.

(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) treatment session per month, including, but not exclusive to, therapy, rehabilitation, case management, and peer recovery support services.

(4) During phase VI, the LBHP, licensure candidate or certified alcohol and drug counselor (CADC) determines the frequency of therapy or rehabilitation service sessions with input from the member.

(5) If an OTP is providing MAT medications to members receiving residential substance use disorder services, the required minimum services for the OTP may be delivered by the residential substance use disorder provider. The OTP provider shall document the provision of these services and the provider delivering such services in the member's service plan.

(g) **Service plans.** In accordance with OAC 450:70-3-8, a service plan shall be completed for each member upon completion of the admission evaluation. The service plan shall be based on the patient's presenting problems or diagnosis, intake assessment, biopsychosocial assessment, and expectations of their recovery.

(1) **Service plan development.** Service plans shall be completed by an LBHP or licensure candidate. Service plans completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP.

(2) **Service plan content.** Service plans shall address, but not limited to, the following:

- (A) Presenting problems or diagnosis;
- (B) Strengths, needs, abilities, and preferences of the member;
- (C) Goals for treatment with specific, measurable, attainable, realistic and time-limited;
- (D) Type and frequency of services to be provided;
- (E) Dated signature of primary service provider;
- (F) Description of member's involvement in, and responses to, the service plan and his or her signature and date;
- (G) Individualized discharge criteria or maintenance;
- (H) Projected length of treatment;
- (I) Measurable long and short term treatment goals;
- (J) Primary and supportive services to be utilized with the patient;
- (K) Type and frequency of therapeutic activities in which patient will participate;
- (L) Documentation of the member's participation in the development of the plan; and
- (M) Staff who will be responsible for the member's treatment.

(3) **Service plan updates.** Service plan updates shall be completed by an LBHP or licensure candidate. Service updates completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Service plan review and updates shall occur no less than every six (6) months and shall occur more frequently if required based upon the service phase or certain circumstances:

~~(A) During phase I, the service plan shall be reviewed and updated a minimum of once monthly.~~

~~(B) During phase II, the service plan shall be reviewed and updated a minimum of once every three (3) months.~~

~~(C) A service plan review shall be completed for the following situations:~~

- ~~(i) Change in goals and objectives based upon member's documented progress, or identification of any new problem(s);~~

- ~~(ii) Change in primary therapist or rehabilitation service provider assignment;~~
- ~~(iii) Change in frequency and types of services provided;~~
- ~~(iv) Critical incident reports;~~
- ~~(v) Sentinel events; or~~
- ~~(vi) Phase change.~~

(A) Change in goals and objectives based upon member's documented progress, or identification of any new problem(s);

(B) Change in primary therapist or rehabilitation service provider assignment;

(C) Change in frequency and types of services provided;

(D) Critical incident reports; and/or

(E) Sentinel events.

(4) **Service plan timeframes.** Service plans shall be completed by the fourth ~~therapy or rehabilitation service~~ visit after admission.

(h) **Progress notes.** Progress notes shall be completed in accordance with OAC 317:30-5-248(3).

(i) **Discharge planning.** All members shall be assessed for biopsychosocial appropriateness of discharge from each level of care using ASAM criteria that includes a list of symptoms for all six (6) dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination by an LBHP or licensure candidate for appropriate placement to a specific level of care based on the following symptoms and situations:

- (1) Acute intoxication and/or withdrawal potential;
- (2) Biomedical conditions and complications;
- (3) Emotional, behavioral or cognitive conditions and complications;
- (4) Readiness to change;
- (5) Relapse, continued use or continued problem potential; and
- (6) Recovery/living environment.

(j) **Service exclusions.** The following services are excluded from coverage:

- (1) Components that are not provided to or exclusively for the treatment of the eligible individual;
- (2) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;
- (3) Telephone calls or other electronic contacts (not inclusive of telehealth);
- (4) Field trips, social, or physical exercise activity groups; ~~and~~

(k) **Reimbursement.** ~~In order to~~ To be eligible for payment, OTPs shall:

- (1) Have an approved provider agreement on file with the OHCA. Through this agreement, the OTP assures that they are in compliance with all applicable federal and State Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.
- (2) Obtain prior authorization for applicable drugs and services by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization for applicable drugs and services, payment is not authorized.
- (3) Record the National Drug Code (NDC) number for each drug used in every encounter at the time of billing.
- (4) Be reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE**

SUBCHAPTER 7. SOONERCARE

PART 1. GENERAL PROVISIONS

317:25-7-7. Referrals for specialty services

(a) ~~PCPs~~ Primary care physicians (PCPs) are required to assure the delivery of medically necessary preventive and primary care medical services, including securing referrals for specialty services. Some services, as defined in ~~OAC~~ Oklahoma Administrative Code (OAC) 317:25-7-2(c) and OAC 317:25-7-10(b), do not require a referral from the PCP. A PCP referral does not guarantee payment, as all services authorized by the PCP must be in the scope of coverage of the SoonerCare Choice program to be considered compensable.

(b) Pursuant to OAC 317:30-3-1(f), SoonerCare Choice referrals must always be made on the basis of medical necessity. Referrals from the PCP are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP.

(c) The PCP and specialty provider are responsible for maintaining appropriate documentation of each referral to support the claims for medically necessary services.

(d) As approved and deemed appropriate, the ~~OHCA~~ Oklahoma Health Care Authority (OHCA) may provide administrative referrals for specialty services. Administrative referrals are only provided by the OHCA under special and extenuating circumstances. Administrative referrals should not be requested as a standard business practice. The OHCA will not process retrospective administrative referrals, unless one (1) of the following exceptions applies:

(1) ~~the~~ The specialty services are referred from an IHS, tribal, or urban Indian clinic;

(2) ~~the~~ The specialty services are referred as the result of an emergency room visit or emergency room follow-up visit; or

~~(3) the specialty services are referred for pre-operative facility services prior to a dental procedure; or~~

~~(4) the retrospective administrative referral request for specialty services is requested from the OHCA within 30 calendar days of the specialty care date of service. If the retrospective administrative referral is requested within the 30 calendar days, the request must include appropriate documentation for the OHCA to approve the request. Appropriate documentation must include:~~

~~(A) proof that the specialist has attempted to collect a PCP referral from the member's assigned PCP; and~~

~~(B) medical documentation to substantiate that the specialty services are medically necessary pursuant to OAC 317:30-3-1(f).~~

(3) The retrospective administrative referral request for specialty services is requested from the OHCA within thirty (30) calendar days of the specialty care date of service.

(A) The referral is requested for urgent/emergent care, including but not limited to, outpatient surgeries, fracture care, and other procedures that require immediate attention.

(B) Annual, routine, and long-term follow up appointments will not be considered for retrospective services. These type of appointment referrals will need to be secured prior to the scheduling of the appointment.

(C) If the retrospective administrative referral is requested within the thirty (30) calendar days, the request must include appropriate documentation for the OHCA to approve the request. Appropriate documentation must include:

(i) Proof that the specialist has attempted to collect a PCP referral from the member's assigned PCP. Documentation should note who the requesting provider communicated with or a copy of the fax verification that was sent to the PCP along with the denial reason; and

(ii) Medical documentation to substantiate that the specialty services are medically necessary pursuant to OAC 317:30-3-1(f).

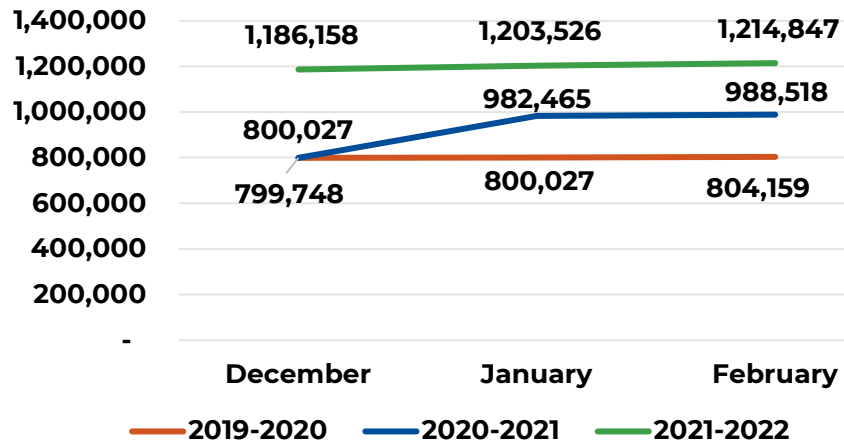
(e) Nothing in this section is intended to absolve the PCP of their obligations in accordance with the conditions set forth in their PCP SoonerCare Choice contract and the rules delineated in OAC 317:30.



OPERATIONAL METRICS

February 2022 Board Meeting

Enrollment & Utilization
Total Enrolled Members

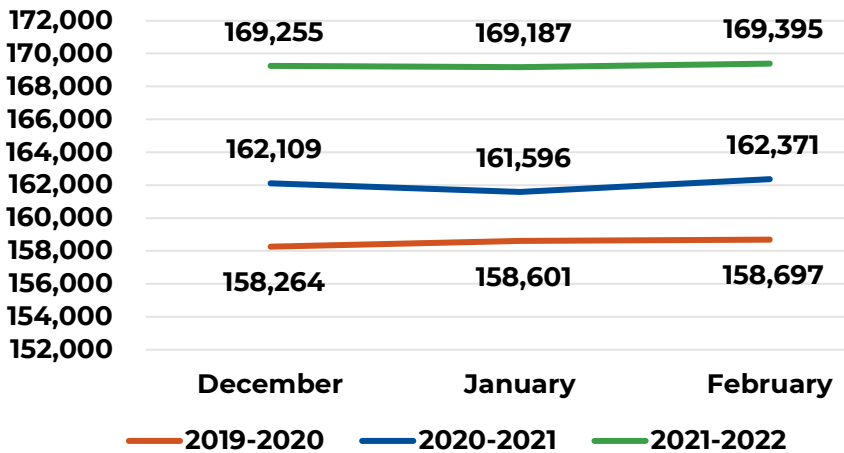


Month	2019-2020	2020-2021	2021-2022
December	799,748	800,027	1,186,158
January	800,027	982,465	1,203,526
February	804,159	988,518	1,214,847

2021 vs 2022	Count Change	Percent Change
December	386,131	48%
January	221,061	23%
February	226,329	23%

2021 vs 2022 Quarterly Percent Change	23%
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Aged/Blind/Disabled Enrolled



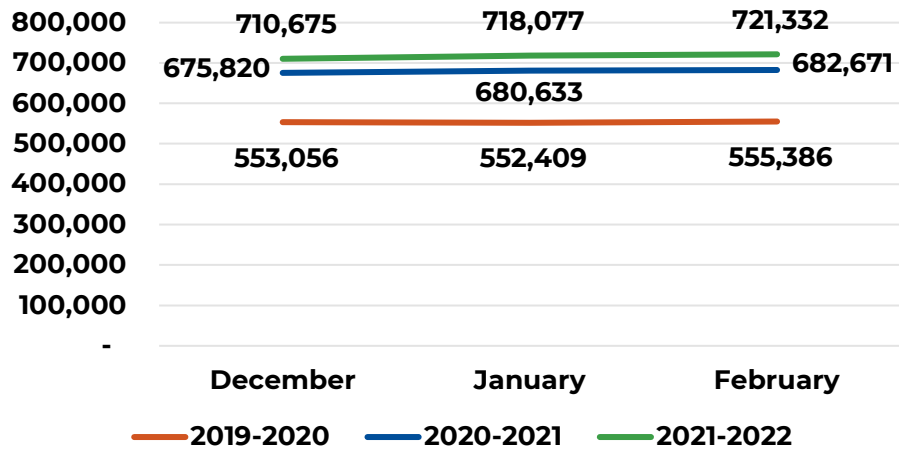
Month	2019-2020	2020-2021	2021-2022
December	158,264	162,109	169,255
January	158,601	161,596	169,187
February	158,697	162,371	169,395

2021 vs 2022	Count Change	Percent Change
December	7,146	4%
January	7,591	5%
February	7,024	4%

2021 vs 2022 Quarterly Percent Change	3%
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Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled

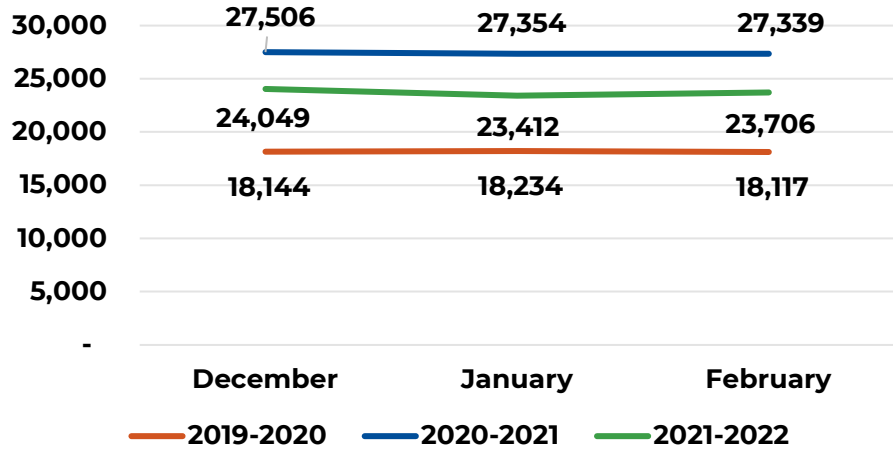


Month	2019-2020	2020-2021	2021-2022
December	553,056	675,820	710,675
January	552,409	680,633	718,077
February	555,386	682,671	721,332

2021 vs 2022	Count Change	Percent Change
December	34,855	5%
January	37,444	6%
February	38,661	6%

2021 vs 2022 Quarterly Percent Change	5%
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Pregnant (Full Scope) Enrolled



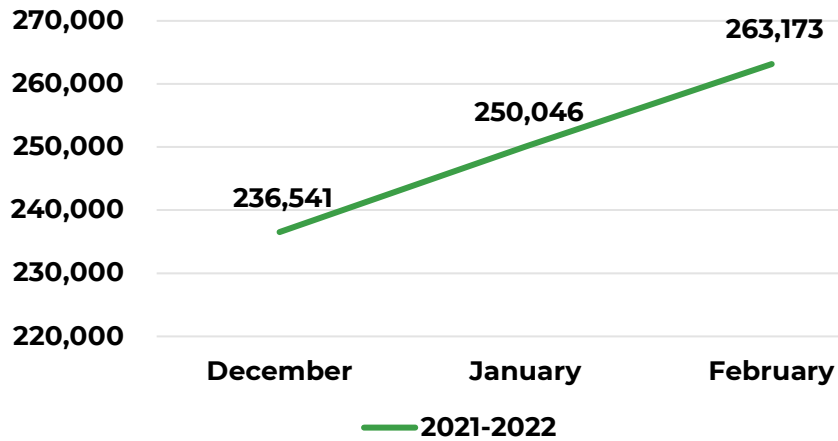
Month	2019-2020	2020-2021	2021-2022
December	18,144	27,506	24,049
January	18,234	27,354	23,412
February	18,117	27,339	23,706

2021 vs 2022	Count Change	Percent Change
December	(3,457)	-13%
January	(3,942)	-14%
February	(3,633)	-13%

2021 vs 2022 Quarterly Percent Change	-9%
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Enrollment & Utilization (Cont.)

Expansion Enrolled (Effective July 2021)

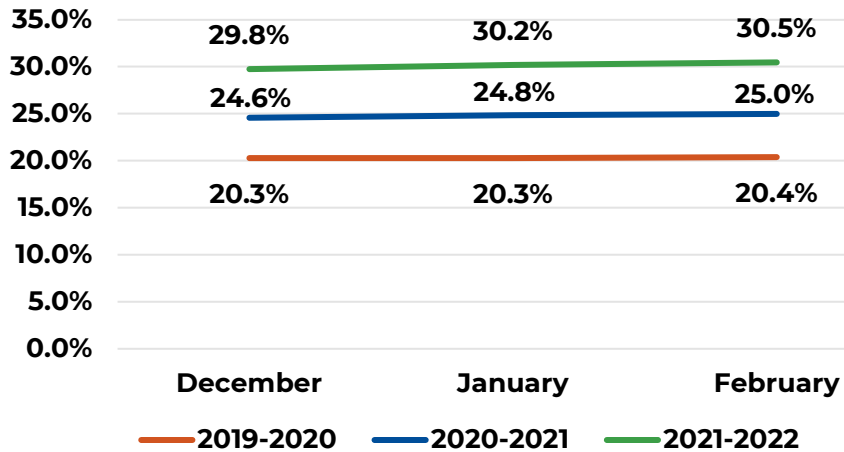


Month	2019-2020	2020-2021	2021-2022
December	-	-	236,541
January	-	-	250,046
February	-	-	263,173

2021 vs 2022	Count Change	Percent Change
December	236,541	#DIV/0!
January	250,046	#DIV/0!
February	263,173	#DIV/0!

2021 vs 2022 Quarterly Percent Change	100%
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Percent of OK Population Enrolled



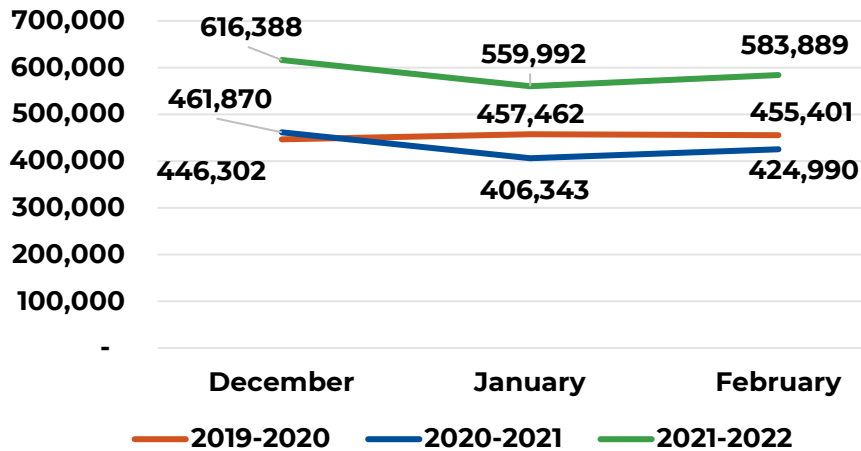
Month	2019-2020	2020-2021	2021-2022
December	20.3%	24.6%	29.8%
January	20.3%	24.8%	30.2%
February	20.4%	25.0%	30.5%

2021 vs 2022	Count Change	Percent Change
December	5.2%	21%
January	5.4%	22%
February	5.5%	22%

2021 vs 2022 Quarterly Percent Change	22%
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Enrollment & Utilization (Cont.)

Total Members Utilization

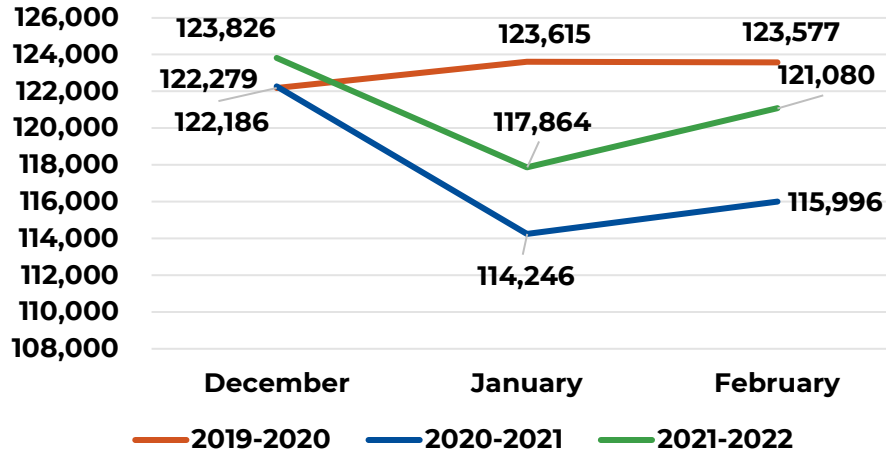


Month	2019-2020	2020-2021	2021-2022
December	446,302	461,870	616,388
January	457,462	406,343	559,992
February	455,401	424,990	583,889

2021 vs 2022	Count Change	Percent Change
December	154,518	33%
January	153,649	38%
February	158,899	37%

2021 vs 2022 Quarterly Percent Change	32%
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Aged/Blind/Disabled Utilization



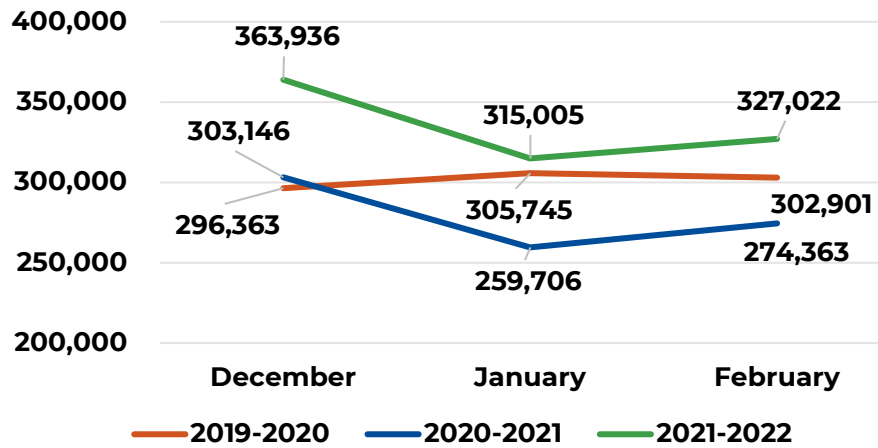
Month	2019-2020	2020-2021	2021-2022
December	122,186	122,279	123,826
January	123,615	114,246	117,864
February	123,577	115,996	121,080

2021 vs 2022	Count Change	Percent Change
December	1,547	1%
January	3,618	3%
February	5,084	4.4%

2021 vs 2022 Quarterly Percent Change	3%
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Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Utilization

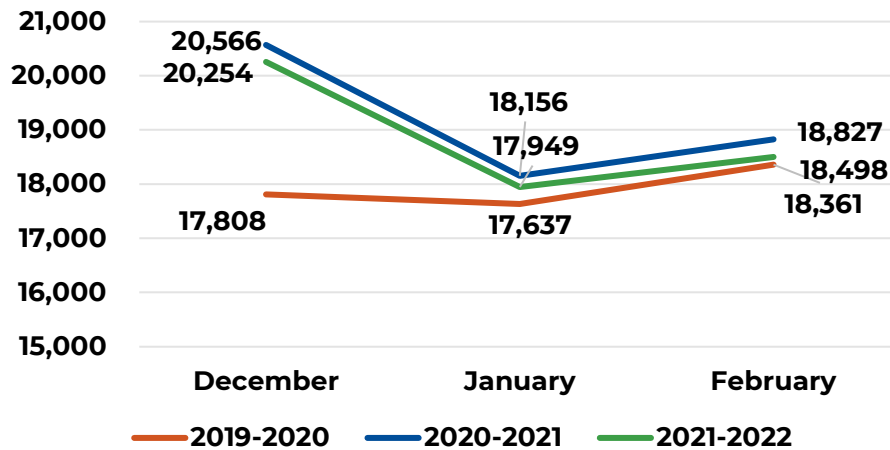


Month	2019-2020	2020-2021	2021-2022
December	296,363	303,146	363,936
January	305,745	259,706	315,005
February	302,901	274,363	327,022

2021 vs 2022	Count Change	Percent Change
December	60,790	20%
January	55,299	21%
February	52,659	19%

2021 vs 2022 Quarterly Percent Change	16%
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Pregnant (Full Scope) Utilization



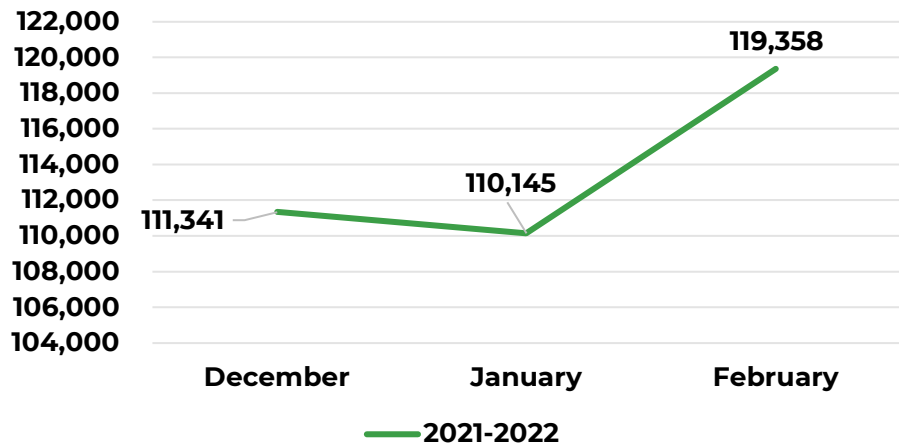
Month	2019-2020	2020-2021	2021-2022
December	17,808	20,566	20,254
January	17,637	18,156	17,949
February	18,361	18,827	18,498

2021 vs 2022	Count Change	Percent Change
December	(312)	-2%
January	(207)	-1%
February	(329)	-2%

2021 vs 2022 Quarterly Percent Change	-3%
--	-----

Enrollment & Utilization (Cont.)

Expansion Utilization (Effective July 2021)

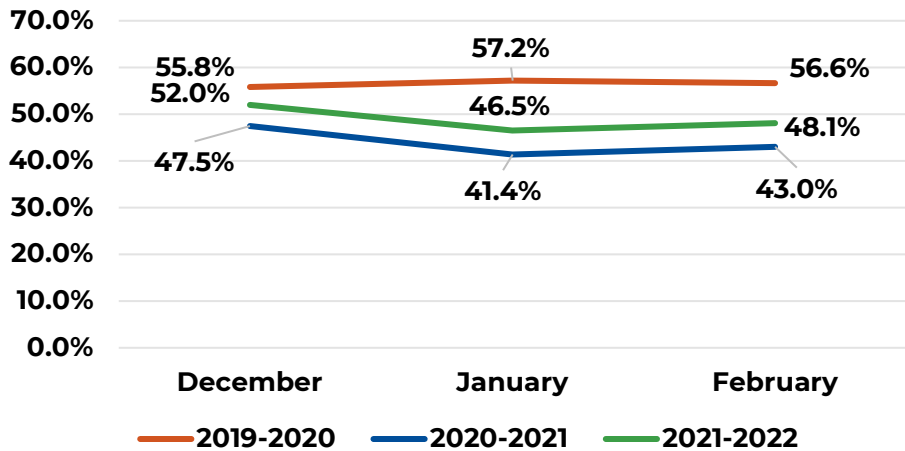


Month	2019-2020	2020-2021	2021-2022
December	-	-	111,341
January	-	-	110,145
February	-	-	119,358

2021 vs 2022	Count Change	Percent Change
December	111,341	#DIV/0!
January	110,145	#DIV/0!
February	119,358	#DIV/0!

2021 vs 2022 Quarterly Percent Change	100%
--	------

Percent of Total Enrolled Members Utilization



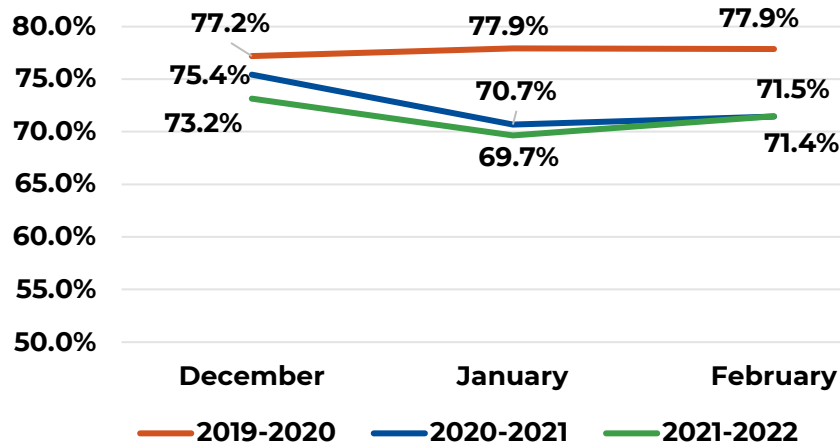
Month	2019-2020	2020-2021	2021-2022
December	55.8%	47.5%	52.0%
January	57.2%	41.4%	46.5%
February	56.6%	43.0%	48.1%

2021 vs 2022	Count Change	Percent Change
December	4.5%	9%
January	5.2%	12%
February	5.1%	12%

2021 vs 2022 Quarterly Percent Change	8%
--	----

Enrollment & Utilization (Cont.)

Percent of Aged/Blind/Disabled Enrolled Members Utilization

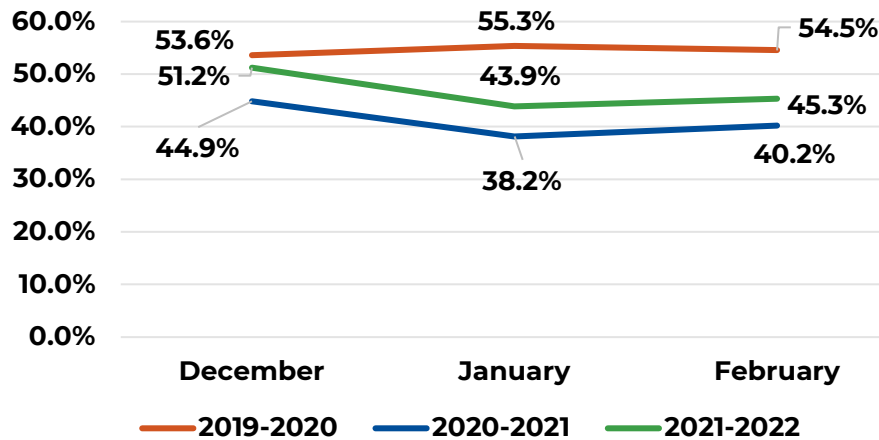


Month	2019-2020	2020-2021	2021-2022
December	77.2%	75.4%	73.2%
January	77.9%	70.7%	69.7%
February	77.9%	71.4%	71.5%

2021 vs 2022	Count Change	Percent Change
December	-2.3%	-3%
January	-1.0%	-1%
February	0.0%	0%

2021 vs 2022 Quarterly Percent Change	0%
--	----

Percent of Children & Parent/Caretaker Enrolled Members Utilization



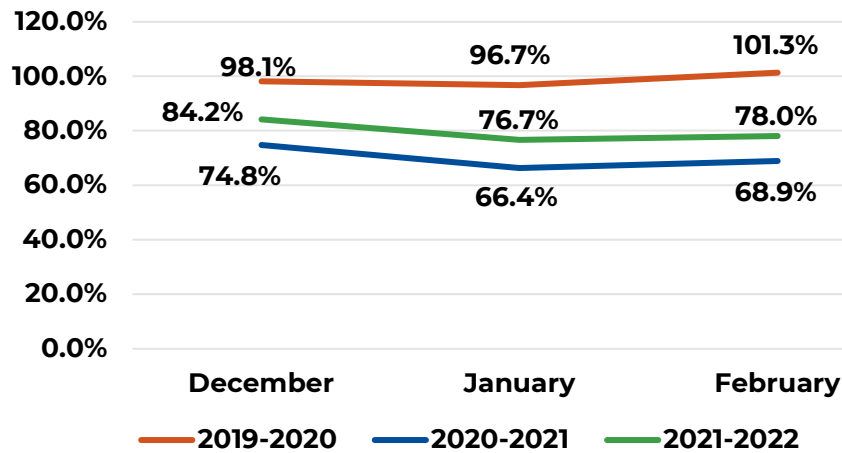
Month	2019-2020	2020-2021	2021-2022
December	53.6%	44.9%	51.2%
January	55.3%	38.2%	43.9%
February	54.5%	40.2%	45.3%

2021 vs 2022	Count Change	Percent Change
December	6.4%	14%
January	5.7%	15%
February	5.1%	13%

2021 vs 2022 Quarterly Percent Change	10%
--	-----

Enrollment & Utilization (Cont.)

Percent of Pregnant (Full Scope) Enrolled Members Utilization

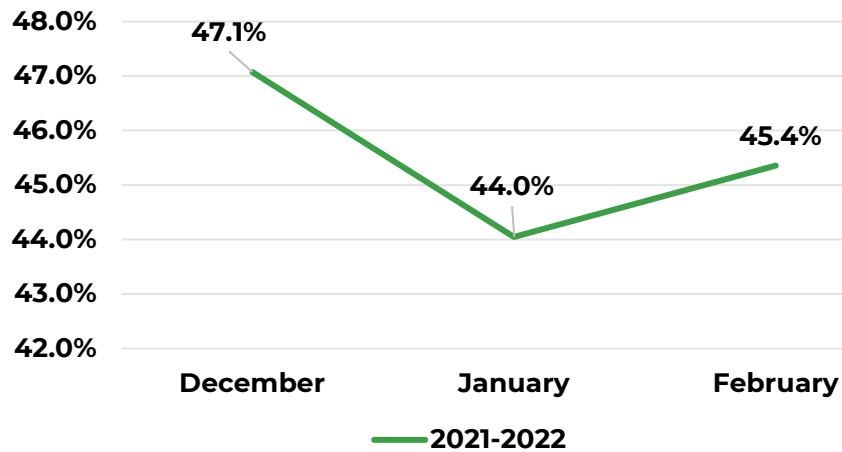


Month	2019-2020	2020-2021	2021-2022
December	98.1%	74.8%	84.2%
January	96.7%	66.4%	76.7%
February	101.3%	68.9%	78.0%

2021 vs 2022	Count Change	Percent Change
December	9.5%	13%
January	10.3%	16%
February	9.2%	13%

2021 vs 2022 Quarterly Percent Change	7%
--	----

Percent of Expansion Enrolled Members Utilization (Effective July 2021)

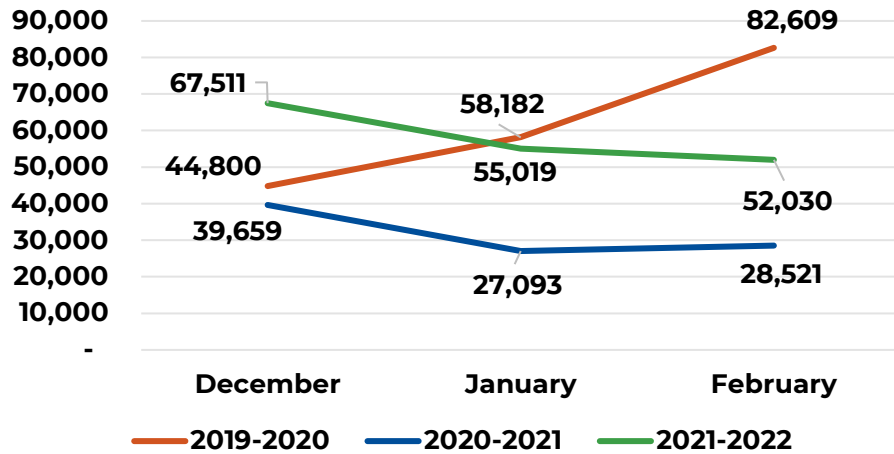


Month	2019-2020	2020-2021	2021-2022
December	0.0%	0.0%	47.1%
January	0.0%	0.0%	44.0%
February	0.0%	0.0%	45.4%

2021 vs 2022	Count Change	Percent Change
December	47.1%	#DIV/0!
January	44.0%	#DIV/0!
February	45.4%	#DIV/0!

2021 vs 2022 Quarterly Percent Change	100%
--	------

Utilization
Emergency Department Visits (Claims)

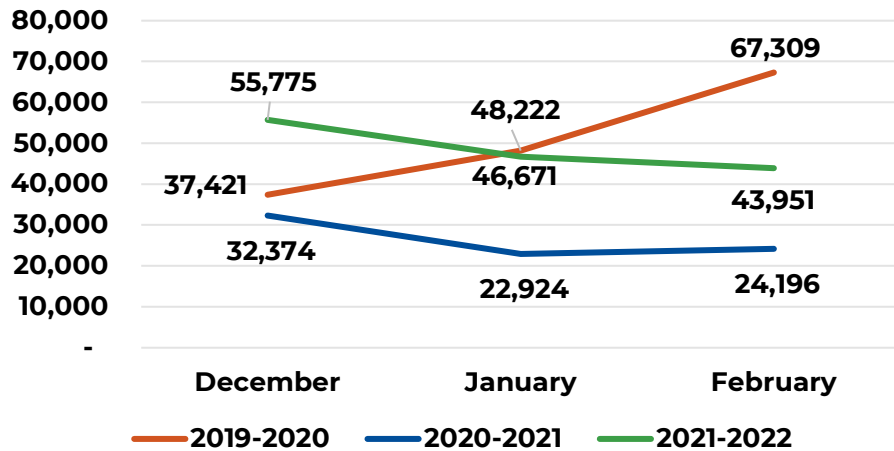


Month	2019-2020	2020-2021	2021-2022
December	44,800	39,659	67,511
January	58,182	27,093	55,019
February	82,609	28,521	52,030

2021 vs 2022	Count Change	Percent Change
December	27,852	70%
January	27,926	103%
February	23,509	82%

2021 vs 2022 Quarterly Percent Change	82%
--	-----

Members Utilizing Emergency Department



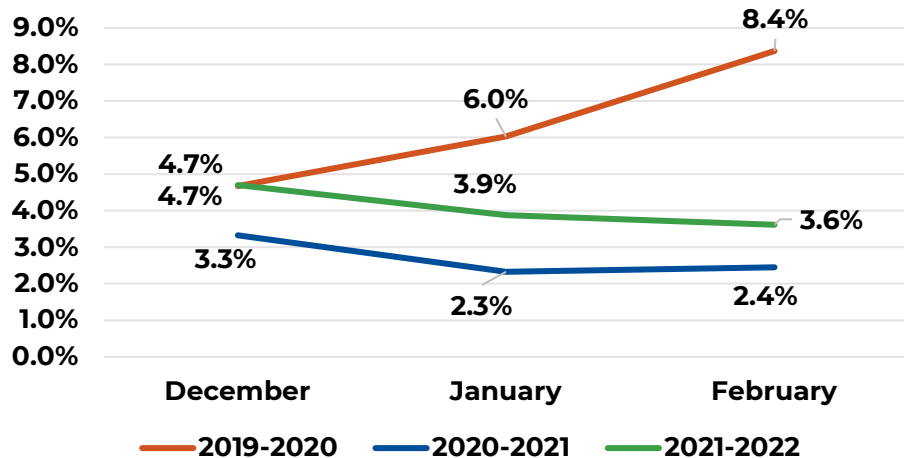
Month	2019-2020	2020-2021	2021-2022
December	37,421	32,374	55,775
January	48,222	22,924	46,671
February	67,309	24,196	43,951

2021 vs 2022	Count Change	Percent Change
December	23,401	72%
January	23,747	104%
February	19,755	82%

2021 vs 2022 Quarterly Percent Change	80%
--	-----

Utilization (Cont.)

Percent Total Enrolled Using ED

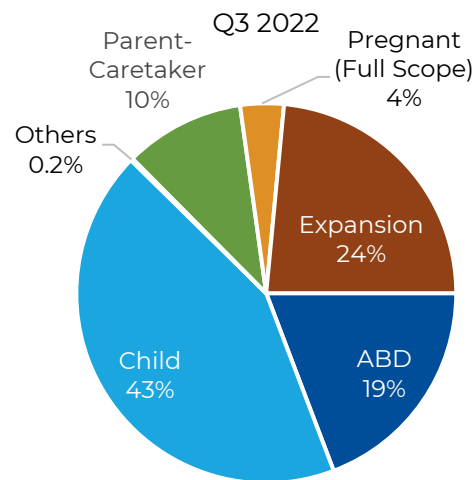
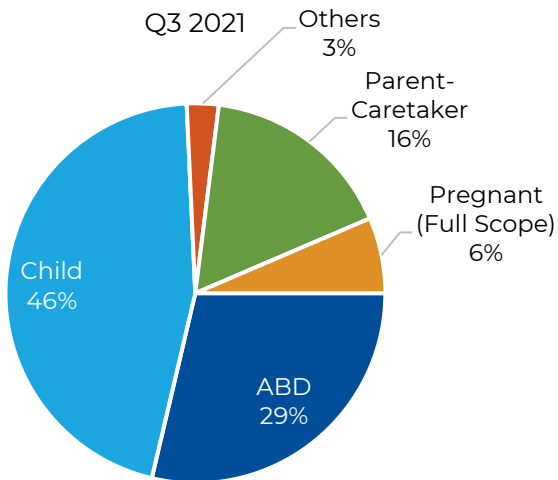


Month	2019-2020	2020-2021	2021-2022
December	4.7%	3.3%	4.7%
January	6.0%	2.3%	3.9%
February	8.4%	2.4%	3.6%

2021 vs 2022	Count Change	Percent Change
December	1.4%	41%
January	1.5%	66%
February	1.2%	48%

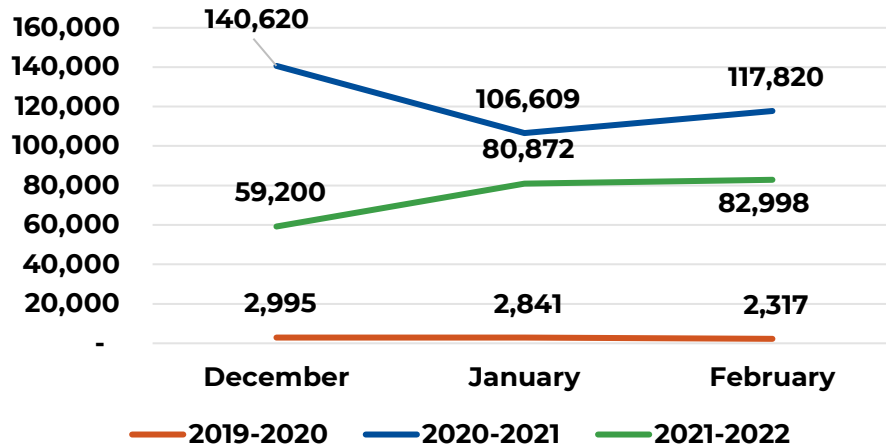
2021 vs 2022 Quarterly Percent Change	47%
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Members Utilizing Emergency Department By Qualifying Group



Utilization (Cont.)

Telemedicine - Total Visits

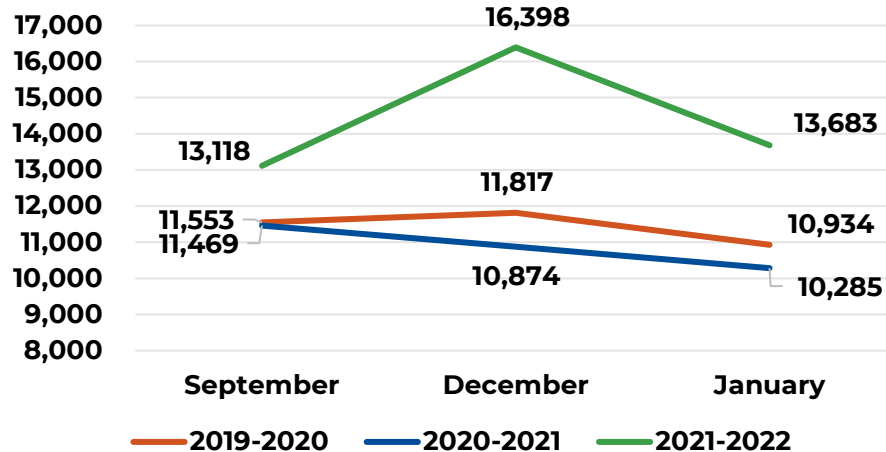


Month	2019-2020	2020-2021	2021-2022
December	2,995	140,620	59,200
January	2,841	106,609	80,872
February	2,317	117,820	82,998

2021 vs 2022	Count Change	Percent Change
December	(81,420)	-58%
January	(25,737)	-24%
February	(34,822)	-30%

2021 vs 2022 Quarterly Percent Change	-39%
--	------

Members With Opioid Claims



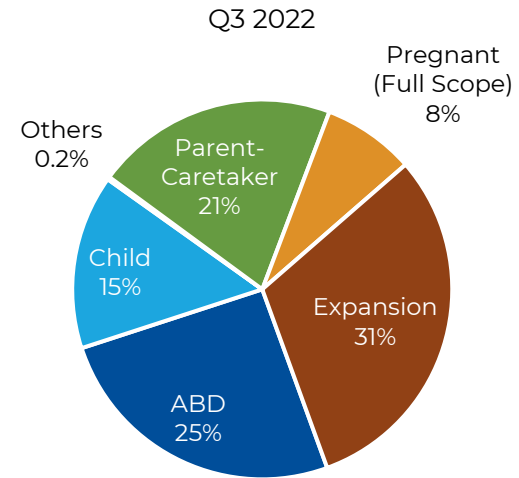
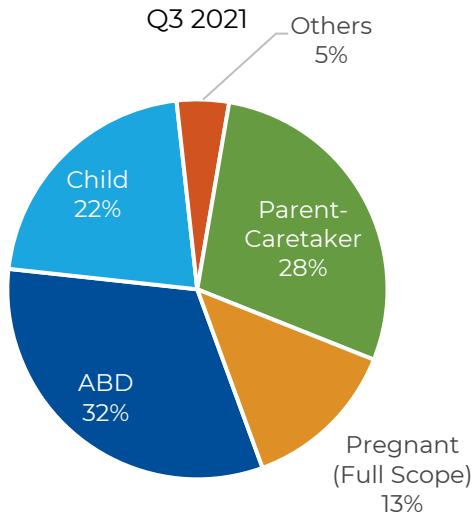
Month	2019-2020	2020-2021	2021-2022
September	11,553	11,469	13,118
December	11,817	10,874	16,398
January	10,934	10,285	13,683

2021 vs 2022	Count Change	Percent Change
September	1,649	14%
December	5,524	51%
January	3,398	33%

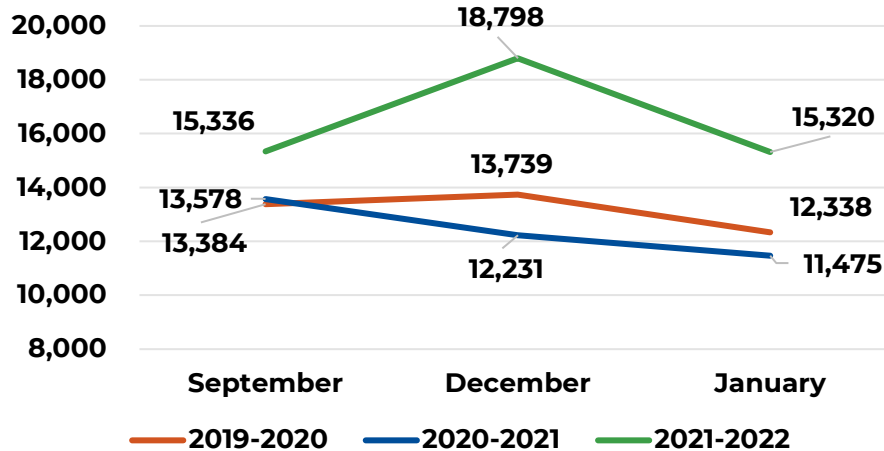
2021 vs 2022 Quarterly Percent Change	N/A
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Utilization (Cont.)

Members With Opioid Claims By Qualifying Group



Total Opioid Claims



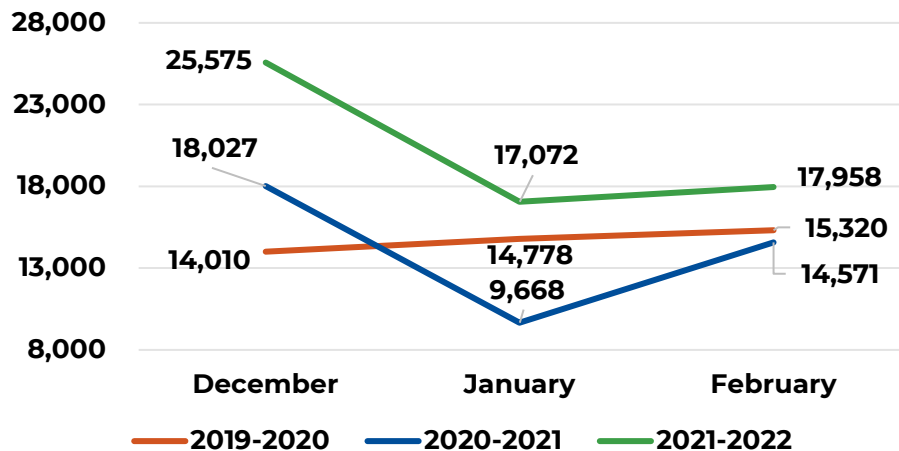
Month	2019-2020	2020-2021	2021-2022
September	13,384	13,578	15,336
December	13,739	12,231	18,798
January	12,338	11,475	15,320

2021 vs 2022	Count Change	Percent Change
September	1,758	13%
December	6,567	54%
January	3,845	34%

2021 vs 2022 Quarterly Percent Change	N/A
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Utilization (Cont.)

Out of State Services - Total Members Utilization



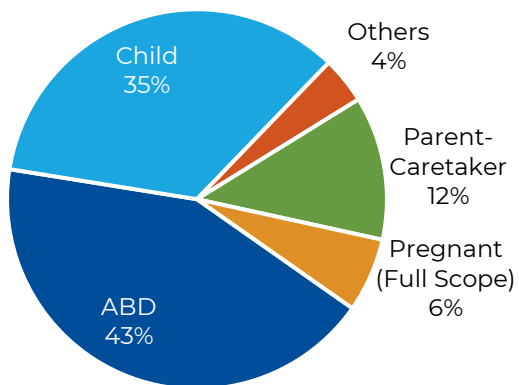
Month	2019-2020	2020-2021	2021-2022
December	14,010	18,027	25,575
January	14,778	9,668	17,072
February	15,320	14,571	17,958

2021 vs 2022	Count Change	Percent Change
December	7,548	42%
January	7,404	77%
February	3,387	23%

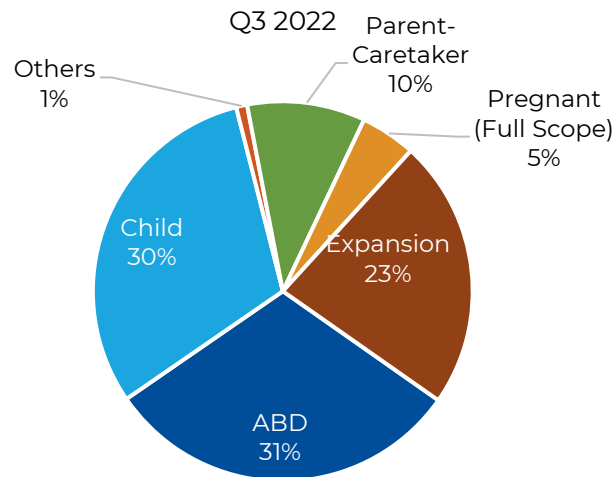
2021 vs 2022 Quarterly Percent Change	42%
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Out of State Services - Total Members Utilization By Qualifying Group

Q3 2021

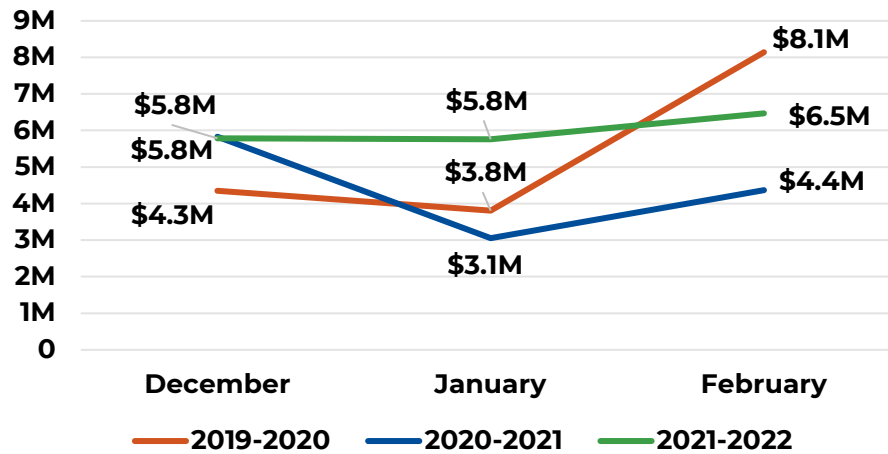


Q3 2022



Utilization (Cont.)

Out of State Services - Total Reimbursements

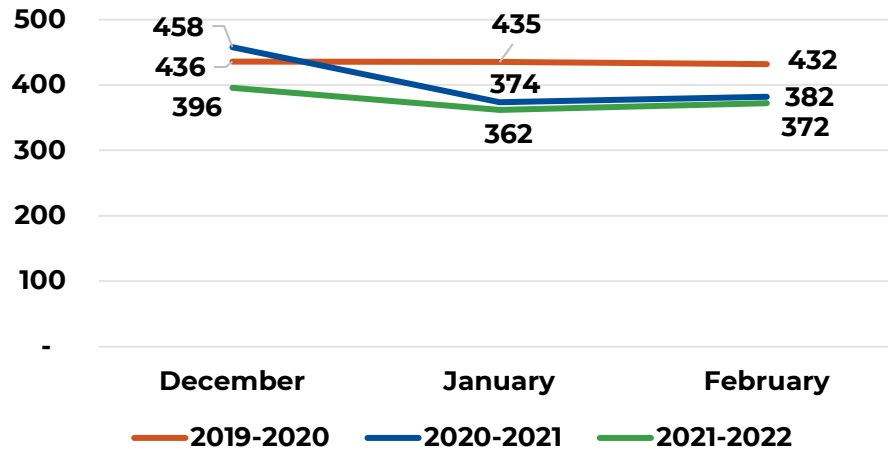


Month	2019-2020	2020-2021	2021-2022
December	\$ 4,344,476	\$ 5,833,800	\$ 5,785,176
January	\$ 3,806,229	\$ 3,053,145	\$ 5,765,543
February	\$ 8,143,437	\$ 4,362,605	\$ 6,471,983

2021 vs 2022	Count Change	Percent Change
December	(48,625)	-1%
January	2,712,398	89%
February	2,109,378	48%

2021 vs 2022 Quarterly Percent Change	36%
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Out of State Services - Total Active Billing Providers



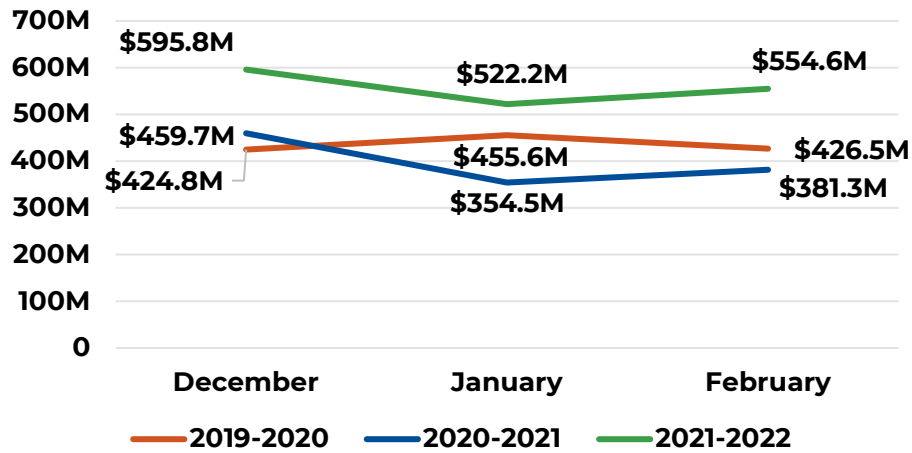
Month	2019-2020	2020-2021	2021-2022
December	436	458	396
January	435	374	362
February	432	382	372

2021 vs 2022	Count Change	Percent Change
December	(62)	-14%
January	(12)	-3%
February	(10)	-3%

2021 vs 2022 Quarterly Percent Change	-9%
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Financials

Total Agency Expenditures



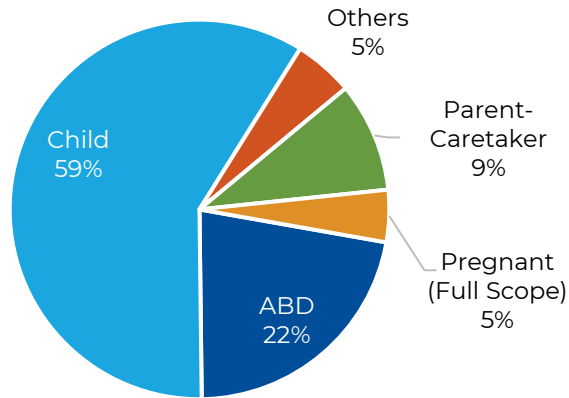
Month	2019-2020	2020-2021	2021-2022
December	\$ 424,823,472	\$ 459,724,468	\$ 595,752,982
January	\$ 455,594,158	\$ 354,546,361	\$ 522,169,377
February	\$ 426,542,165	\$ 381,265,704	\$ 554,584,199

2021 vs 2022	Count Change	Percent Change
December	\$ 136,028,514	30%
January	\$ 167,623,016	47%
February	\$ 173,318,495	45%

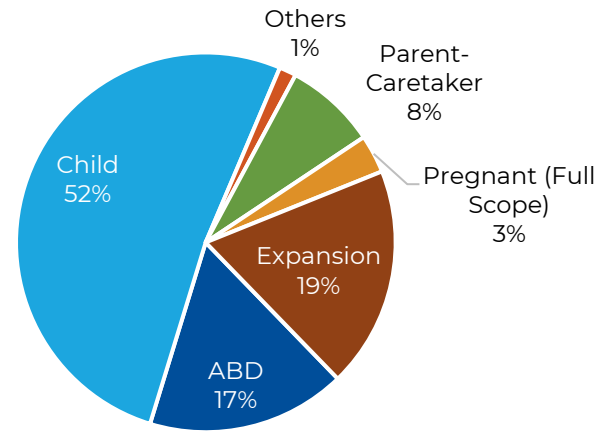
2021 vs 2022 Quarterly Percent Change	40%
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Total Agency Members Utilization by Qualifying Group

Q3 2021

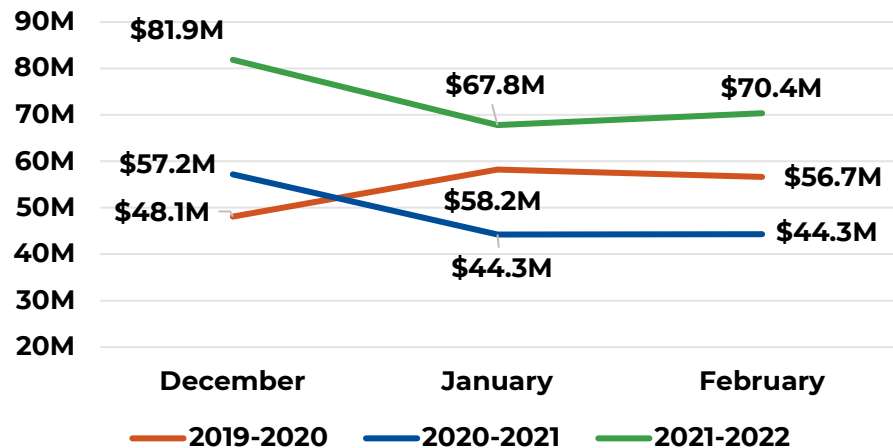


Q3 2022



Financials (Cont.)

Inpatient Services Expenditures



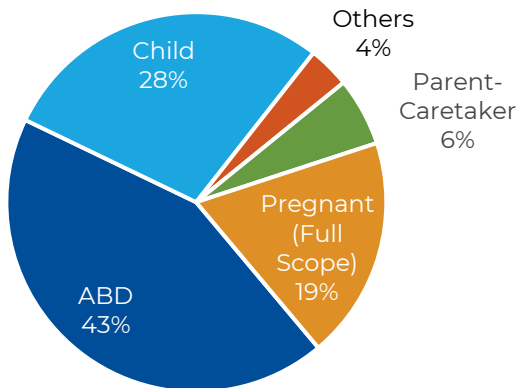
Month	2019-2020	2020-2021	2021-2022
December	\$ 48,126,611	\$ 57,207,382	\$ 81,880,554
January	\$ 58,227,191	\$ 44,269,268	\$ 67,797,560
February	\$ 56,664,871	\$ 44,290,006	\$ 70,353,490

2021 vs 2022	Count Change	Percent Change
December	\$ 24,673,172	43%
January	\$ 23,528,292	53%
February	\$ 26,063,484	59%

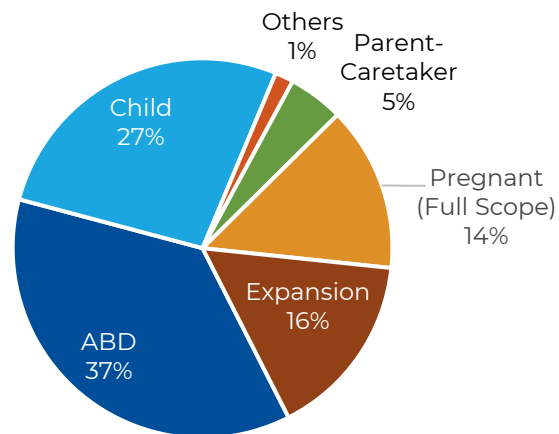
2021 vs 2022 Quarterly Percent Change	51%
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Inpatient Services Members Utilization by Qualifying Group

Q3 2021

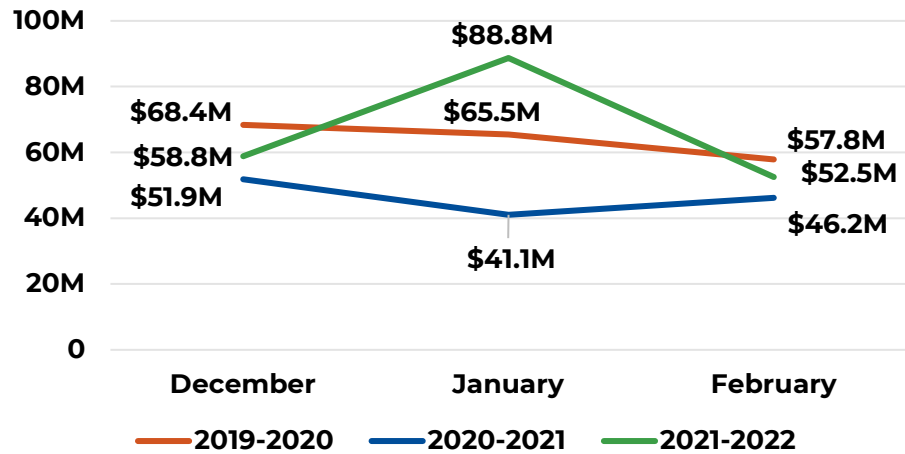


Q3 2022



Financials (Cont.)

Nursing Facility Expenditures

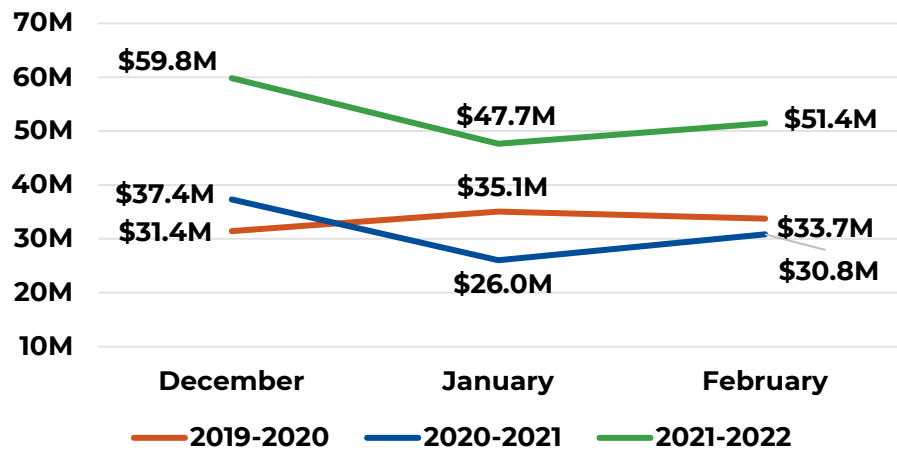


Month	2019-2020	2020-2021	2021-2022
December	\$ 68,427,427	\$ 51,884,328	\$ 58,804,991
January	\$ 65,465,203	\$ 41,055,316	\$ 88,758,190
February	\$ 57,845,196	\$ 46,188,590	\$ 52,546,125

2021 vs 2022	Count Change	Percent Change
December	\$ 6,920,663	13%
January	\$ 47,702,874	116%
February	\$ 6,357,535	14%

2021 vs 2022 Quarterly Percent Change	44%
--	-----

Outpatient Hospital Expenditures



Month	2019-2020	2020-2021	2021-2022
December	\$ 31,434,857	\$ 37,364,308	\$ 59,845,340
January	\$ 35,082,437	\$ 26,039,481	\$ 47,672,980
February	\$ 33,721,724	\$ 30,849,240	\$ 51,434,820

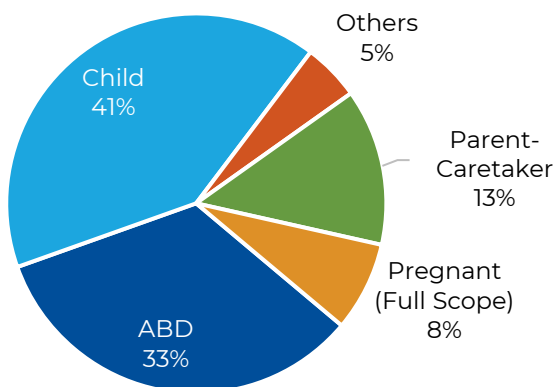
2021 vs 2022	Count Change	Percent Change
December	\$ 22,481,032	60%
January	\$ 21,633,498	83%
February	\$ 20,585,580	67%

2021 vs 2022 Quarterly Percent Change	69%
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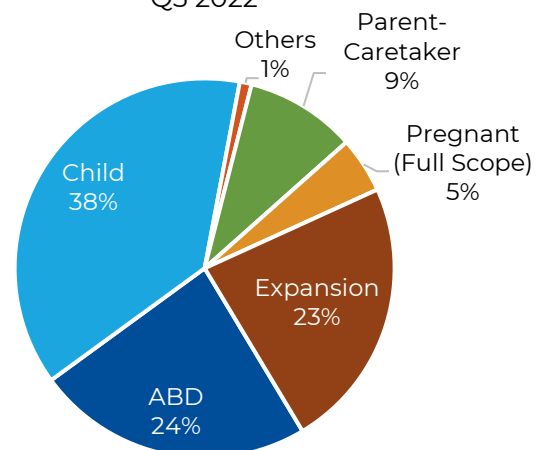
Financials (Cont.)

Outpatient Hospital Members Utilization by Qualifying Group

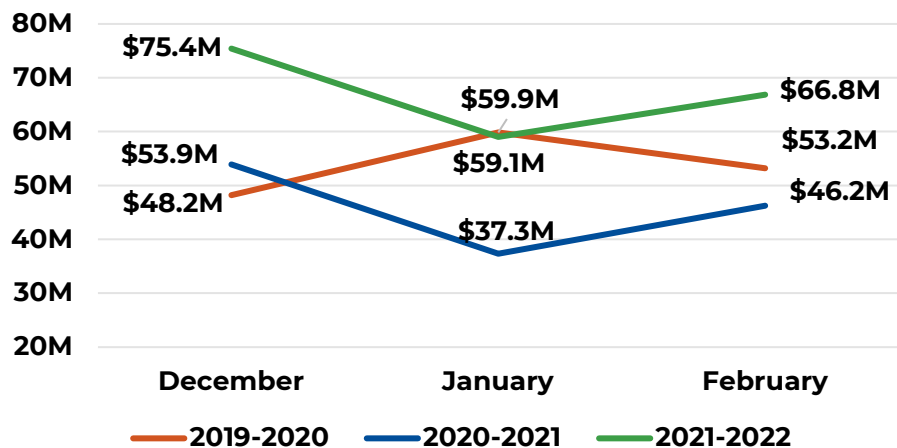
Q3 2021



Q3 2022



Physician Expenditures



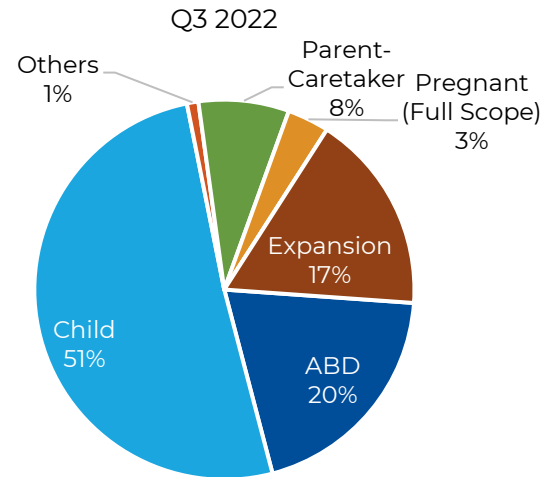
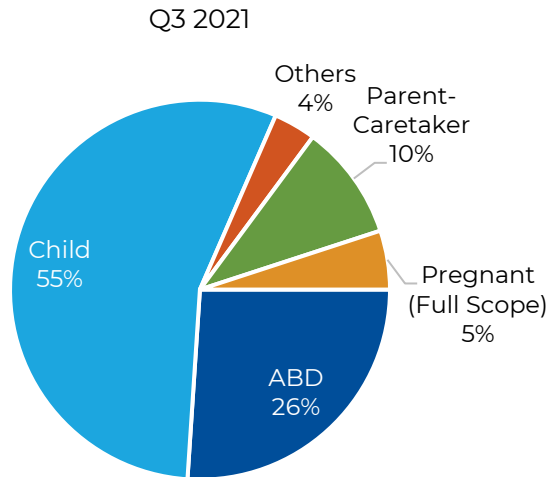
Month	2019-2020	2020-2021	2021-2022
December	\$ 48,218,787	\$ 53,913,607	\$ 75,421,272
January	\$ 59,862,834	\$ 37,341,844	\$ 59,056,350
February	\$ 53,201,300	\$ 46,246,182	\$ 66,843,581

2021 vs 2022	Count Change	Percent Change
December	\$ 21,507,665	40%
January	\$ 21,714,506	58%
February	\$ 20,597,399	45%

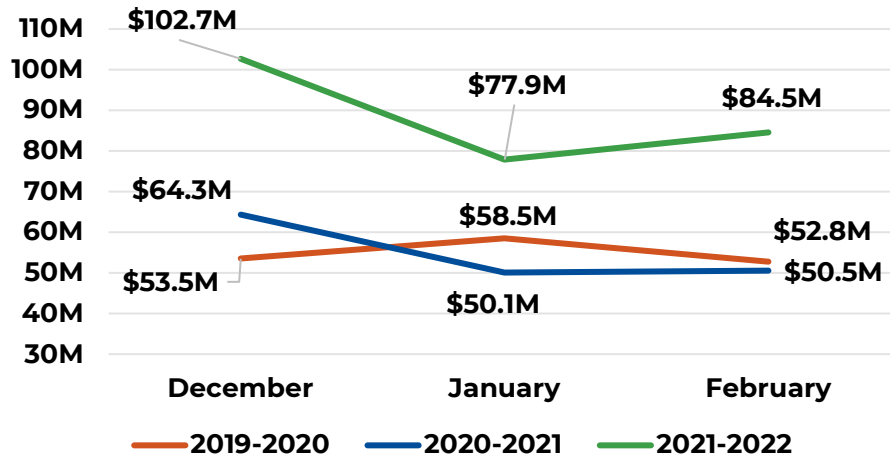
2021 vs 2022 Quarterly Percent Change	46%
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Financials (Cont.)

Physician Members Utilization By Qualifying Group



Prescribed Drugs Expenditures



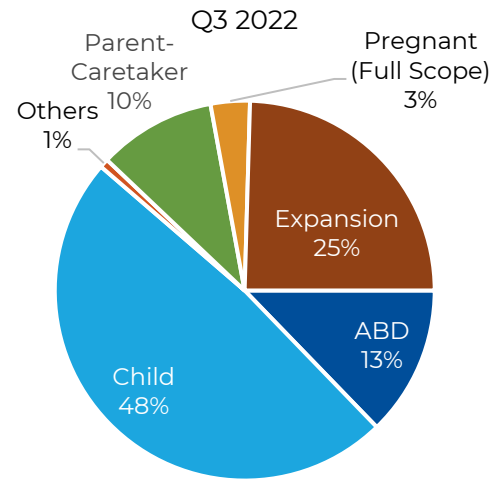
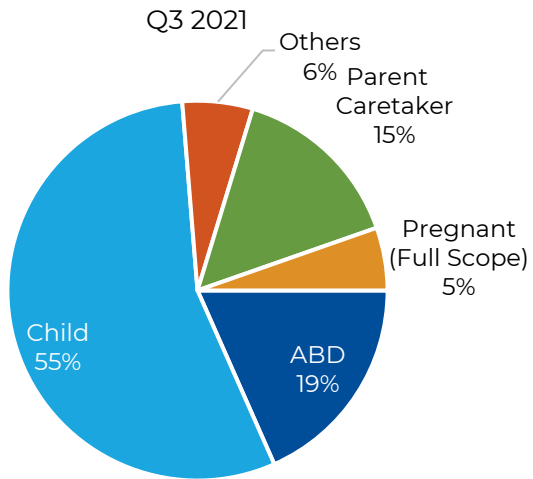
Month	2019-2020	2020-2021	2021-2022
December	\$ 53,494,879	\$ 64,327,298	\$ 102,671,595
January	\$ 58,488,543	\$ 50,128,033	\$ 77,902,283
February	\$ 52,789,059	\$ 50,496,271	\$ 84,543,969

2021 vs 2022	Count Change	Percent Change
December	\$ 38,344,297	60%
January	\$ 27,774,250	55%
February	\$ 34,047,698	67%

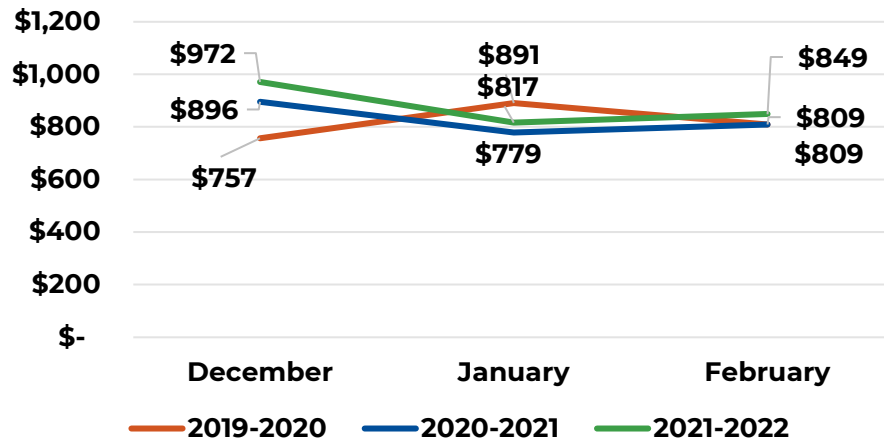
2021 vs 2022 Quarterly Percent Change	Percent Change
	61%

Financials (Cont.)

Prescribed Drugs Members Utilization By Qualifying Group



Average Per Total Member Served



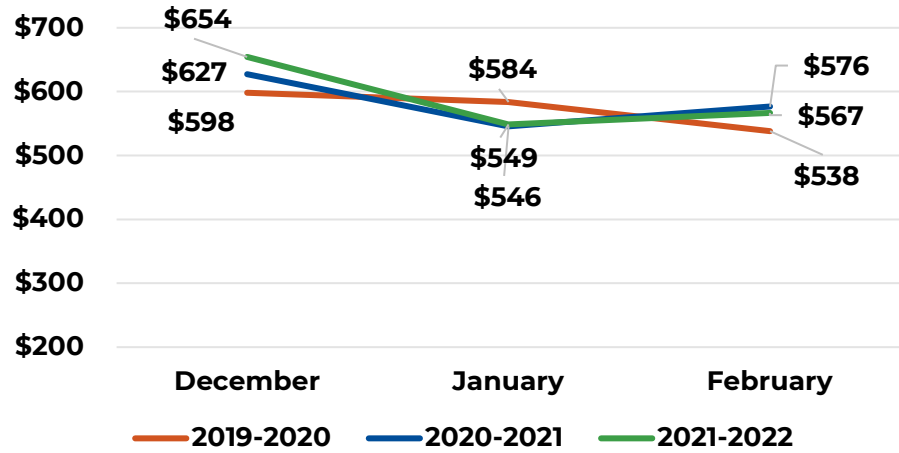
Month	2019-2020	2020-2021	2021-2022
December	\$ 757	\$ 896	\$ 972
January	\$ 891	\$ 779	\$ 817
February	\$ 809	\$ 809	\$ 849

2021 vs 2022	Count Change	Percent Change
December	\$ 75	8%
January	\$ 38	5%
February	\$ 40	5%

2021 vs 2022 Quarterly Percent Change	9%
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Financials (Cont.)

Average Per Child (Under 21) Member Served

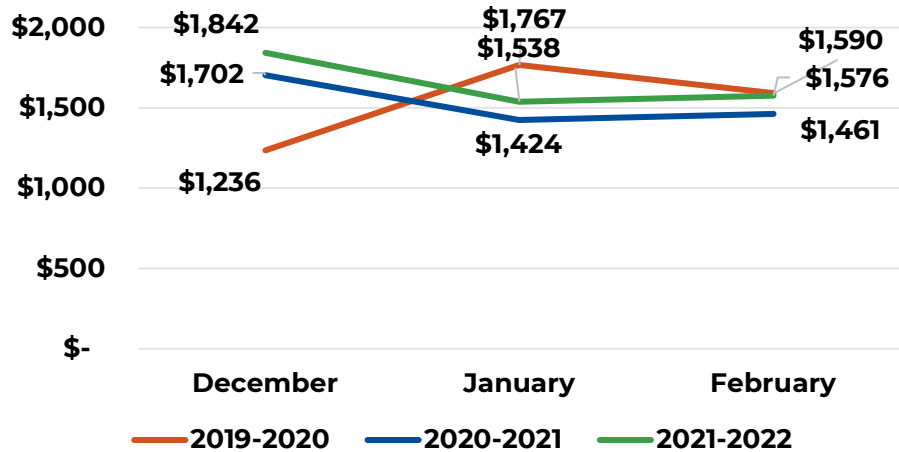


Month	2019-2020	2020-2021	2021-2022
December	\$ 598	\$ 627	\$ 654
January	\$ 584	\$ 546	\$ 549
February	\$ 538	\$ 576	\$ 567

2021 vs 2022	Count Change	Percent Change
December	\$ 27	4%
January	\$ 3	0%
February	\$ (10)	-2%

2021 vs 2022 Quarterly Percent Change	5%
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Average Per Aged/Blind/Disabled Member Served



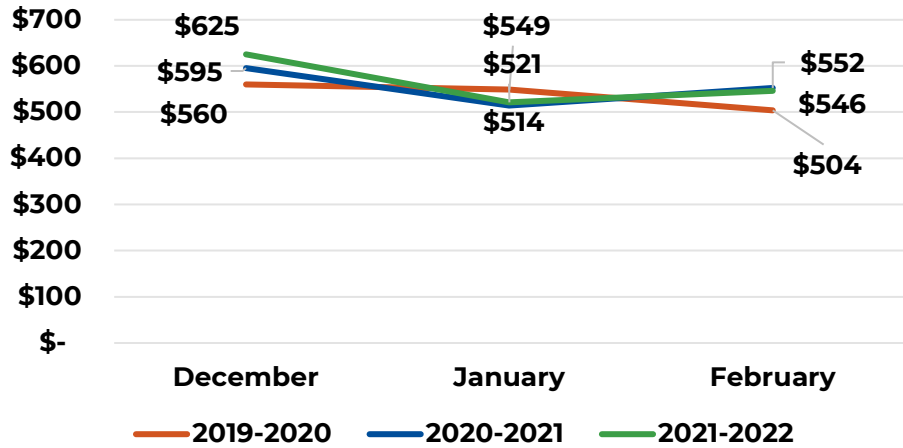
Month	2019-2020	2020-2021	2021-2022
December	\$ 1,236	\$ 1,702	\$ 1,842
January	\$ 1,767	\$ 1,424	\$ 1,538
February	\$ 1,590	\$ 1,461	\$ 1,576

2021 vs 2022	Count Change	Percent Change
December	\$ 139	8%
January	\$ 113	8%
February	\$ 114	8%

2021 vs 2022 Quarterly Percent Change	8%
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Financials (Cont.)

Average Per Children & Parent/Caretaker Member Served

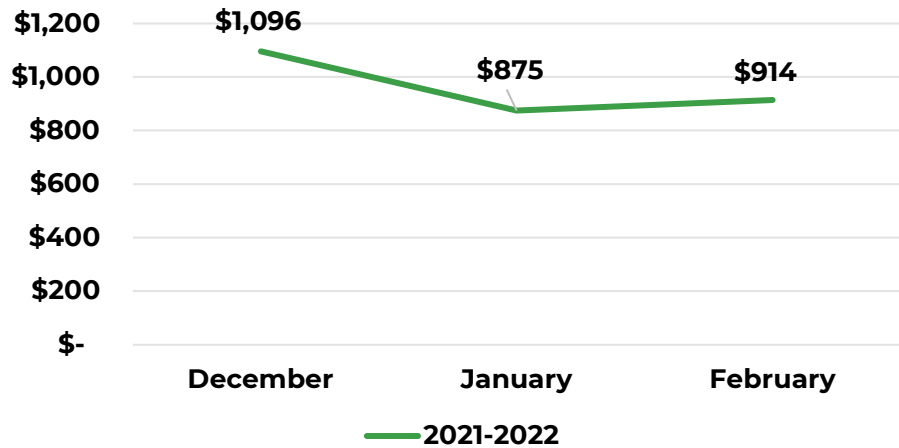


Month	2019-2020	2020-2021	2021-2022
December	\$ 560	\$ 595	\$ 625
January	\$ 549	\$ 514	\$ 521
February	\$ 504	\$ 552	\$ 546

2021 vs 2022	Count Change	Percent Change
December	\$ 30	5%
January	\$ 7	1%
February	\$ (7)	-1%

2021 vs 2022 Quarterly Percent Change	5%
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Average Per Expansion Member Served (Effective July 2021)

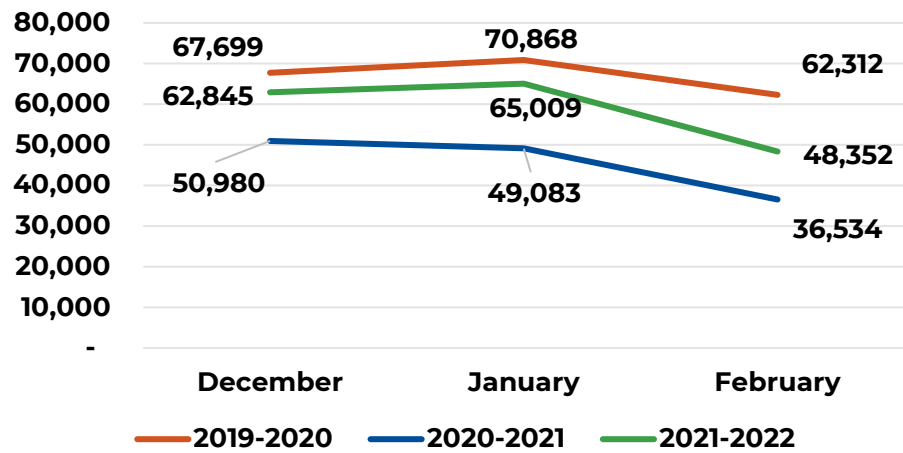


Month	2019-2020	2020-2021	2021-2022
December	\$ -	\$ -	\$ 1,096
January	\$ -	\$ -	\$ 875
February	\$ -	\$ -	\$ 914

2021 vs 2022	Count Change	Percent Change
December	\$ 1,096	#DIV/0!
January	\$ 875	#DIV/0!
February	\$ 914	#DIV/0!

2021 vs 2022 Quarterly Percent Change	100%
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Call Center
Call Center - Member Calls Answered

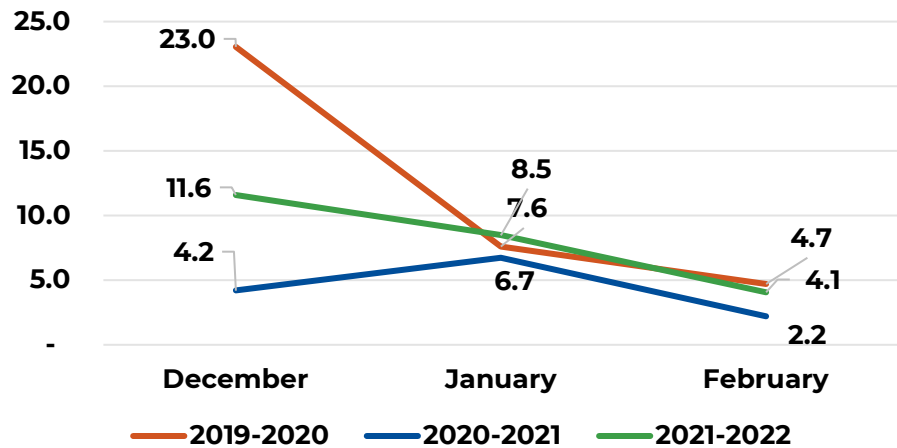


Month	2019-2020	2020-2021	2021-2022
December	67,699	50,980	62,845
January	70,868	49,083	65,009
February	62,312	36,534	48,352

2021 vs 2022	Count Change	Percent Change
December	11,865	23%
January	15,926	32%
February	11,818	32%

2021 vs 2022 Quarterly Percent Change	29%
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Call Center - Average Wait Time (In Seconds)

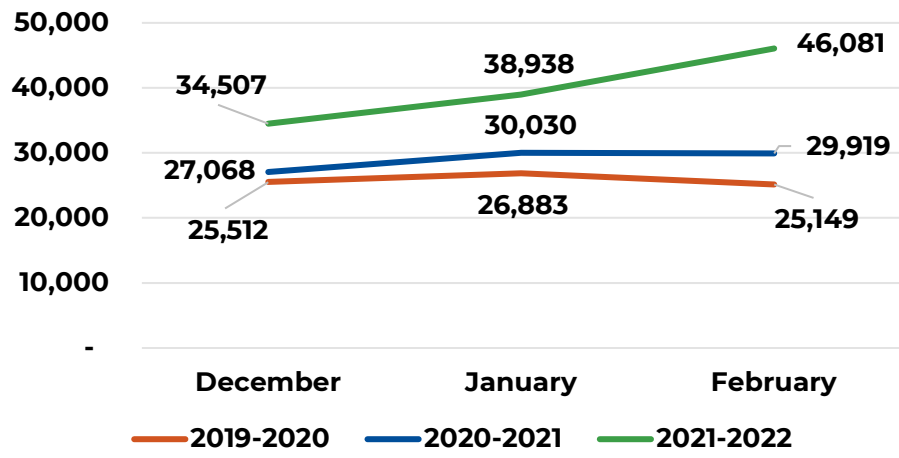


Month	2019-2020	2020-2021	2021-2022
December	23.0	4.2	11.6
January	7.6	6.7	8.5
February	4.7	2.2	4.1

2021 vs 2022	Count Change	Percent Change
December	7	176%
January	2	26%
February	2	85%

2021 vs 2022 Quarterly Percent Change	N/A
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Prior Authorization
Prior Authorization - Total Combined - Total Completed PA Volume

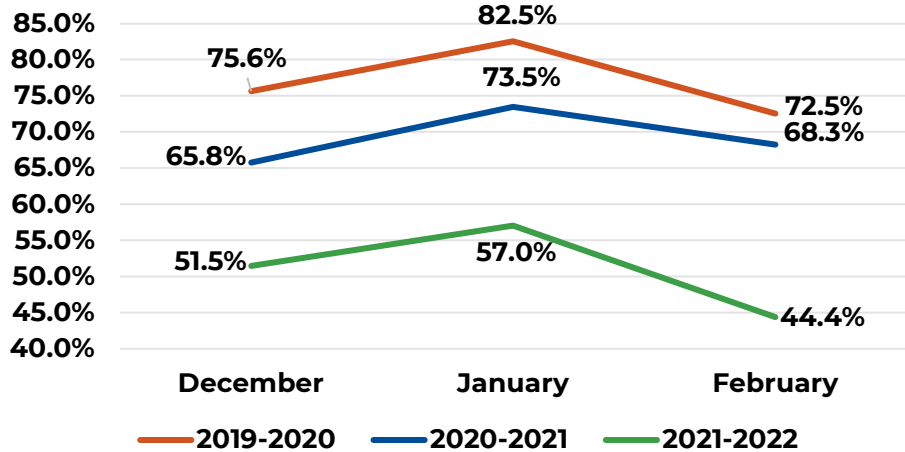


Month	2019-2020	2020-2021	2021-2022
December	25,512	27,068	34,507
January	26,883	30,030	38,938
February	25,149	29,919	46,081

2021 vs 2022	Count Change	Percent Change
December	7,439	27%
January	8,908	30%
February	16,162	54%

2021 vs 2022 Quarterly Percent Change	37%
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Prior Authorization - Total Combined - Total Percent Completed 0-6 Days



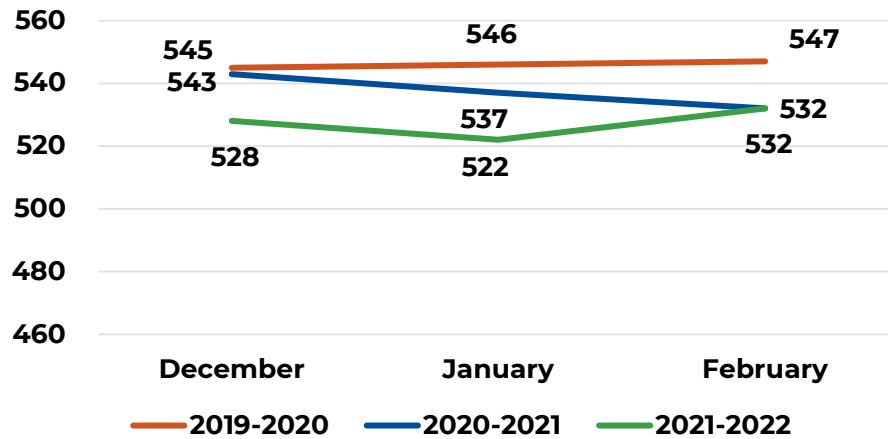
Month	2019-2020	2020-2021	2021-2022
December	75.6%	65.8%	51.5%
January	82.5%	73.5%	57.0%
February	72.5%	68.3%	44.4%

2021 vs 2022	Count Change	Percent Change
December	-14.3%	-22%
January	-16.4%	-22%
February	-23.8%	-35%

2021 vs 2022 Quarterly Percent Change	-27%
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Agency Stats & Provider Network

OHCA Admin - Number of FTEs

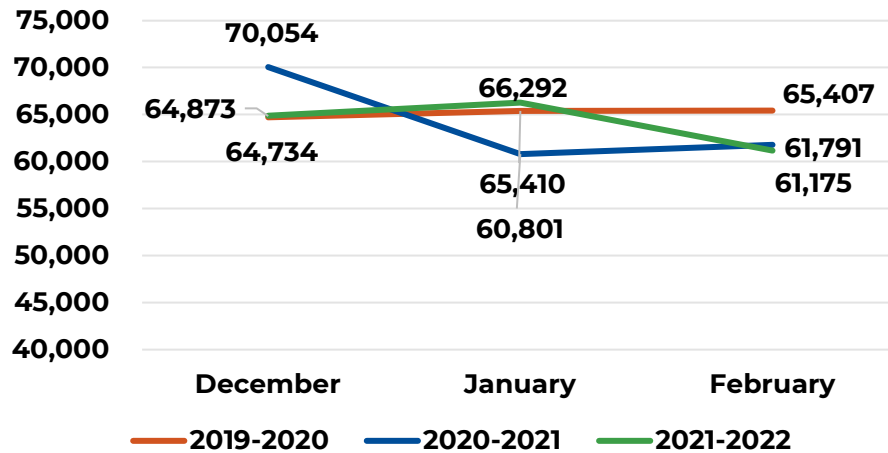


Month	2019-2020	2020-2021	2021-2022
December	545	543	528
January	546	537	522
February	547	532	532

2021 vs 2022	Count Change	Percent Change
December	(15)	-3%
January	(15)	-3%
February	-	0.0%

2021 vs 2022 Quarterly Percent Change	N/A
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Total Providers



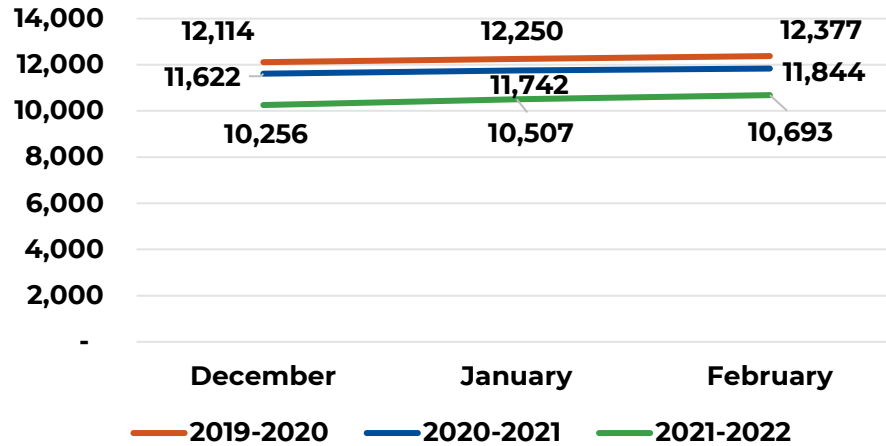
Month	2019-2020	2020-2021	2021-2022
December	64,734	70,054	64,873
January	65,410	60,801	66,292
February	65,407	61,791	61,175

2021 vs 2022	Count Change	Percent Change
December	(5,181)	-7%
January	5,491	9%
February	(616)	-1%

2021 vs 2022 Quarterly Percent Change	-6%
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Agency Stats & Provider Network (Cont.)

Mental Health Providers (In-State Only)

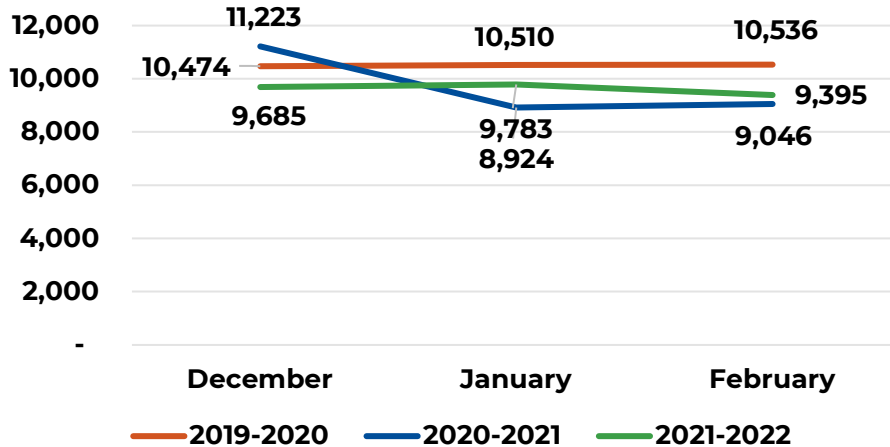


Month	2019-2020	2020-2021	2021-2022
December	12,114	11,622	10,256
January	12,250	11,742	10,507
February	12,377	11,844	10,693

2021 vs 2022	Count Change	Percent Change
December	(1,366)	-12%
January	(1,235)	-11%
February	(1,151)	-10%

2021 vs 2022 Quarterly Percent Change	-7%
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Physicians (In-State Only)



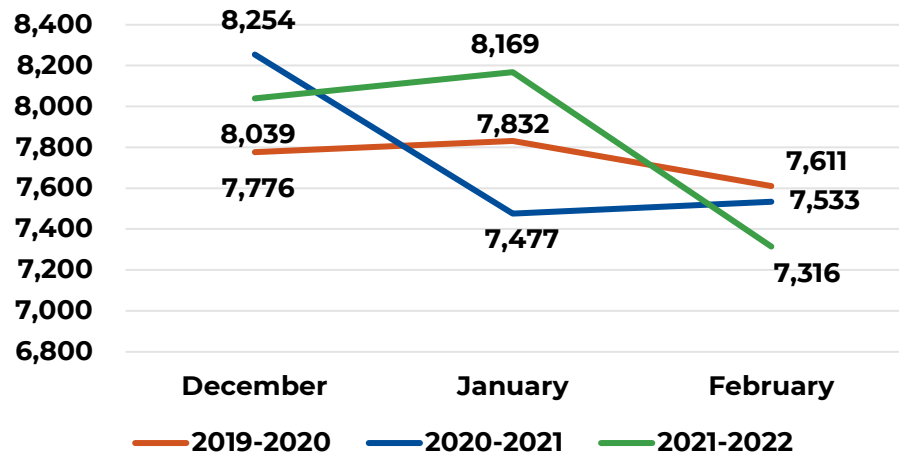
Month	2019-2020	2020-2021	2021-2022
December	10,474	11,223	9,685
January	10,510	8,924	9,783
February	10,536	9,046	9,395

2021 vs 2022	Count Change	Percent Change
December	(1,538)	-14%
January	859	10%
February	349	4%

2021 vs 2022 Quarterly Percent Change	-13%
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Agency Stats & Provider Network (Cont.)

Primary Care Providers (In-State Only)

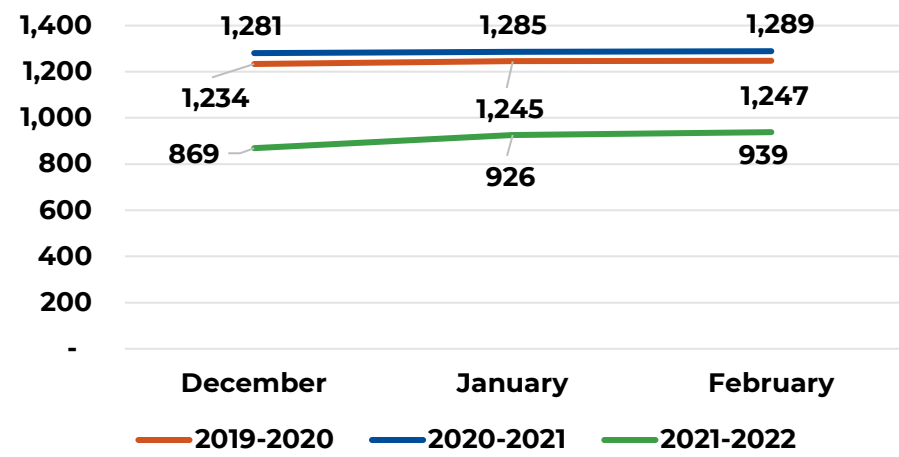


Month	2019-2020	2020-2021	2021-2022
December	7,776	8,254	8,039
January	7,832	7,477	8,169
February	7,611	7,533	7,316

2021 vs 2022	Count Change	Percent Change
December	(215)	-3%
January	692	9%
February	(217)	-3%

2021 vs 2022 Quarterly Percent Change	-1%
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Dentists (In-State Only)



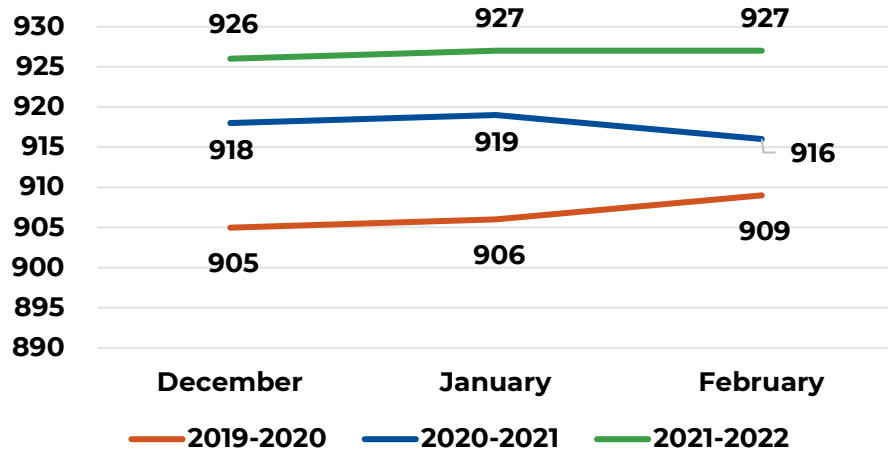
Month	2019-2020	2020-2021	2021-2022
December	1,234	1,281	869
January	1,245	1,285	926
February	1,247	1,289	939

2021 vs 2022	Count Change	Percent Change
December	(412)	-32%
January	(359)	-28%
February	(350)	-27%

2021 vs 2022 Quarterly Percent Change	-27%
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Agency Stats & Provider Network (Cont.)

Pharmacy (In-State Only)

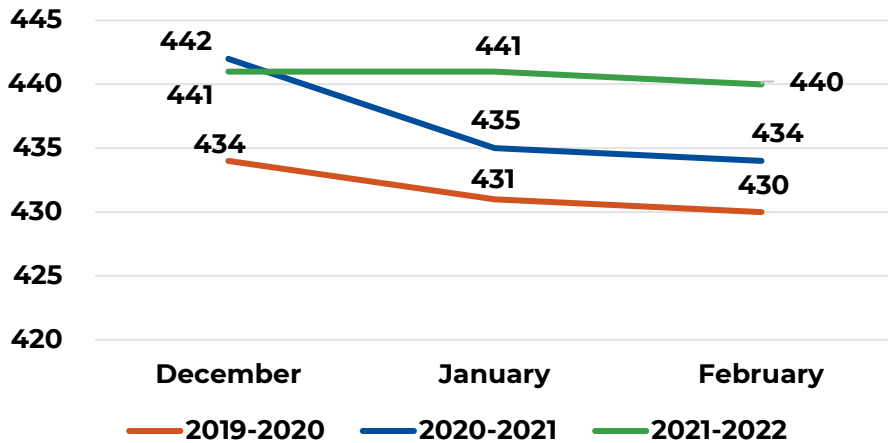


Month	2019-2020	2020-2021	2021-2022
December	905	918	926
January	906	919	927
February	909	916	927

2021 vs 2022	Count Change	Percent Change
December	8	1%
January	8	1%
February	11	1%

2021 vs 2022 Quarterly Percent Change	4%
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Extended Care Facilities (In-State Only)



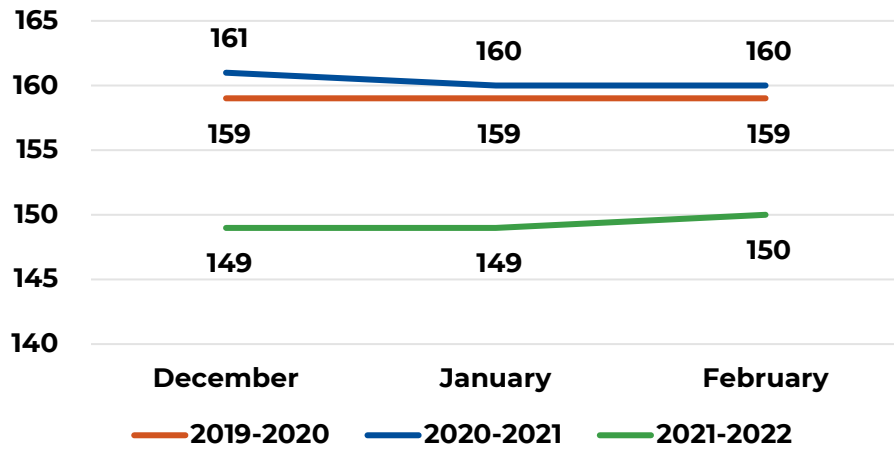
Month	2019-2020	2020-2021	2021-2022
December	434	442	441
January	431	435	441
February	430	434	440

2021 vs 2022	Count Change	Percent Change
December	(1)	0%
January	6	1%
February	6	1%

2021 vs 2022 Quarterly Percent Change	0%
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Agency Stats & Provider Network (Cont.)

Hospitals (In-State Only)



Month	2019-2020	2020-2021	2021-2022
December	159	161	149
January	159	160	149
February	159	160	150

2021 vs 2022	Count Change	Percent Change
December	(12)	-7%
January	(11)	-7%
February	(10)	-6%

2021 vs 2022 Quarterly Percent Change	-7%
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